A Private Health Plan Option Strategy for Medicare

Paul B. Ginsburg, Glenn M. Hackbarth

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PREFACE

This study, supported under a cooperative agreement with the Health Care Financing Administration, analyzes ways to increase the use of private health plans in the Medicare program. It reviews a wide range of policy options to improve the functioning of the current program of risk contracting with health maintenance organizations and other private health plans and suggests additional research and demonstration efforts by the Office of Research and Demonstrations.

During the period over which this study was conducted, one author, Dr. Ginsburg, was a senior economist at The RAND Corporation; the other, Mr. Hackbarth, was the Washington Counsel for Intermountain Health Care and a consultant to RAND. Dr. Ginsburg is now the Executive Director of the Physician Payment Review Commission. Mr. Hackbarth is now the Deputy Administrator of the Health Care Financing Administration. (His contribution to this study was complete before he assumed this position.) Both authors had firsthand experience with Medicare private health plan legislation in their previous positions—Ginsburg with the Congressional Budget Office and Hackbarth with the Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services.

An earlier version of Sec. II was published in *Health Affairs* (Ginsburg and Hackbarth, 1986).

SUMMARY

Medicare is currently pursuing a dual approach to containing program costs. One approach involves acting as a prudent buyer of medical services on behalf of beneficiaries. Examples of this approach include prospective payment for hospital care through Diagnosis Related Groups (DRGs), peer review of medical decisions through Peer Review Organizations (PROs), and applying an "inherent reasonableness" approach to physician payment. We call this the "federal approach" because of government's role in deciding what services to pay for and how much to pay.

THE PHPO APPROACH

The other approach, which we call the "private health plan option (PHPO) approach," decentralizes many of these decisions to private organizations. Health plans make decisions as to appropriate use of services and payments to hospitals and physicians. Their success in enrolling beneficiaries and earning a profit will depend on how well they organize the delivery of health care.

The potential for the PHPO approach to provide better value for the beneficiary is based on the combination of broad incentives and decentralization of decisionmaking. Reducing use of services is the area where private health plans are likely to have the most success. Potential problems for a plan include the need for federal contributions to better reflect enrollees' medical care needs relative to their counterparts enrolled in other plans or remaining in the fee-for-service system, and whether marketing costs offset a significant part of the cost savings. Although the available evidence on quality of care indicates that private health plans have quality comparable to that in the fee-for-service sector, the issue merits monitoring because of incentives to underserve. Medical ethics, malpractice threats, and the importance of plan reputation may well be sufficient to deter underservice, and avoiding the provision of unnecessary services could result in higher quality of care.

The Congress authorized the PHPO approach through provisions of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). (The TEFRA provisions regarding private health plans constitute Section 1876 of the Social Security Act.) Medicare is now permitted to pay Health Maintenance Organizations (HMOs) and Competitive Medical

Plans (CMPs) on a capitation basis, with the capitation payment based on the costs to Medicare incurred on behalf of comparable beneficiaries who remain in the fee-for-service system. The provisions began to be implemented in April 1985. As of February 1987, roughly 150 health plans have qualified for risk contracts and have enrolled almost 850,000 beneficiaries.

Although Section 1876 has some limitations, it is indeed a very solid foundation for the PHPO approach. Its essence is voluntary enrollment in private health plans and competition among the plans and between the plans and traditional Medicare. Private health plans will have to pass a market test—convincing beneficiaries that they offer a superior combination of price, access, and quality.

Proposals to pursue the PHPO strategy further, some of which have been labeled "vouchers," would build on Section 1876, modifying one or more of its provisions. For example, the Administration's 1985 legislative proposal would expand the definition of an eligible plan to include traditional private insurance, permit employers to offer enrollment in their health benefits plan, and change some other provisions. It is not a radical departure from current law.

CAPITATION POLICY OPTIONS

Section 1876 reflects a compromise between three philosophical positions. One reflects a general belief in the potential of market forces in health care, and that the best way to harness market forces is to have consumers choose on a periodic basis between competing private health plans. A second reflects a strong support of the potential of HMOs, not as a device to facilitate competition, but as a way to remove price as a barrier to consumers obtaining health care without losing control of costs. A third reflects skepticism about Medicare paying providers on a basis other than costs, fearing that unnecessarily large payments will result, increasing Medicare outlays. Given these perspectives, a pure capitation system was not enacted, but one that places significant limitations on the behavior of health plans.

Regulation of Premiums and Profits

The most important liability of Section 1876 is its regulation of premiums and profits. The rules attempt to limit the premium for basic Medicare services to costs in traditional Medicare and to limit profit rates to those derived from service to private patients. The purpose was twofold: to limit windfalls from enrolling relatively healthy

beneficiaries and to reduce the incentive to earn large profits by reducing services inappropriately.

These limitations are written as follows: The plan's premium for basic Medicare benefits plus the actuarial value of its cost sharing cannot exceed the actuarial value of the cost sharing its enrollees would have incurred had they remained in traditional Medicare. In addition, the premium that a plan charges for supplemental services not covered by Medicare may not exceed the plan's "adjusted community rate" (ACR) for those services. The ACR is the amount that the plan would charge its Medicare enrollees if it calculated its premium in the same way that it does its premiums for private enrollees, with an adjustment for the higher use of health care services by the elderly. Finally, if the plan's ACR for basic Medicare benefits is less than the capitation payment from Medicare, the difference must be passed on to Medicare enrollees in the form of expanded benefits or reduced out-of-pocket payments, or returned to the government.

Criticism of premium and profit regulation focuses on the likelihood of unintended effects. Regulation of the premium on basic benefits, for example, could impede a "top of the line" plan that uses physicians who charge more than the Medicare allowed amount to fee-for-service patients. Regulation of profits may also severely limit newer plans, which tend to have high start-up costs, thus reducing the incentive for them to participate. Small plans may also run into problems in calculating the ACR, since their utilization experience will tend to be heavily influenced by the presence or absence of individuals with "catastrophic" expenses. Others suspect that regulation of premiums and profits does not constrain HMOs and CMPs, but only because creative accounting permits the plans to evade them. We recommend that regulation of premiums and profits be abandoned.

Minimum Benefits and Cash Rebates

In contrast to limits on premiums and profits, we regard the requirement that benefits be at least as comprehensive as basic Medicare as a useful one. Although not a major issue when only HMOs and CMPs can qualify, it would be important if traditional indemnity plans were permitted, as the Administration has proposed.

The argument against minimum benefit requirements is that they interfere with beneficiaries' abilities to trade off medical care for other goods and services. But HMOs and CMPs already give beneficiaries many opportunities to do so, for example, through restricting choice of provider. On the other hand, plans with substantial cost sharing could result in strong patterns of biased selection (only healthy people would

choose these plans), and "free rider" incentives could lead some to underinsure and have their cost sharing be treated as a bad debt. Finally, in view of Medicare beneficiaries' behavior in purchasing private supplemental coverage, one might question how many would want a plan with substantial cost sharing, and how this number would compare to the number that inadvertently purchased such plans.

Our analysis of the current prohibition of cash rebates is similar. Although rebates are useful in theory, we doubt that HMOs and CMPs have been seriously limited in developing attractive benefit packages, and administrative problems could arise.

Marketing, Enrollment, and Consumer Information

Under current policies, Medicare polices enrollment and marketing activities of health plans but does not provide consumer information about options available to beneficiaries. Medicare could increase enrollment growth by supporting the brokering of information to beneficiaries about health plans available to them. This would be especially effective during the next few years, as much of the present marketing tasks involve the *concept* of HMOs or CMPs, information that might be underproduced by the market. Medicare could either inform beneficiaries directly, as the Office of Personnel Management does in the Federal Employees Health Benefits Program, or fund private organizations to act as brokers.

Plan Qualifications

Current rules do not permit plans that offer unrestricted choice of physicians to market to the Medicare population. Given Medicare's substantial purchasing power and absence of selling costs, it seems unlikely that many plans offering unrestricted choice could compete with Medicare other than on the basis of a windfall from biased selection. Although one could argue that the market should decide the competitive issue, we doubt that the probability of success is high enough to warrant the assignment of HCFA's limited management resources. Any attractive proposals could be implemented under demonstration authority.

On the other hand, permitting risk contracting with employment-based plans is an attractive option, since it would give a substantial number of beneficiaries access to many of the innovations in health care financing being pursued by employers today—such as preferred provider arrangements (PPAs) and "managed care"—as well as HMOs. Employers may be able to disseminate information about alternative plans at lower cost than the direct efforts that HMOs and CMPs must now make to enroll Medicare beneficiaries. Setting an appropriate

payment rate to those beneficiaries in a particular employer's plan should take into account differences in utilization patterns across employers or industries. Basing the rate on an employer's prior Medicare claims would be the most effective way to accomplish this.

Mandatory Vouchers

A mandatory voucher would involve three changes from current law—broadening the definition of a qualified plan to include traditional insurance with unlimited choice of provider, basing the amount of the Medicare entitlement on factors other than the cost of services under traditional Medicare, and not offering a residual government plan for those not electing a private option. The first two changes could be pursued independently, as discussed above and below. Thus, the merits of a mandatory voucher revolve around the maintenance of a federal fee-for-service plan.

It would be premature to consider abandoning traditional Medicare. Private health plans have not passed a market test at this point. Further, Medicare is such a highly popular program, protecting both the elderly and their adult children from the financial ravages of illness and increasing access to medical care for many, that contemplating radical changes would be a mistake.

PRICING

Currently, payments to health plans with risk contracts are set at 95 percent of the adjusted average per capita cost (AAPCC), which is an estimate of what Medicare spends for comparable beneficiaries who use the fee-for-service system. Although this method is more sophisticated than pricing mechanisms used by many employers offering HMO options, it could benefit from improvement in a number of areas.

The most important issue concerns biased selection. Some evidence indicates that those enrolling in HMOs and CMPs would have had lower claims than beneficiaries of the same age and sex had they remained in the fee-for-service system. This not only has serious budgetary implications for Medicare but could confer windfall gains or losses on individual health plans.

Although the evidence that biased selection will be a serious problem over the long term is not conclusive, the consequences of substantial patterns of selection are so serious that it is worth taking steps now to reduce it. Options with the greatest potential at present involve making use of data on health services utilization during the years before

enrollment for new and recent enrollees. Thus, if a health plan's recent enrollees had had higher or lower utilization than their cohorts before enrollment, payment rates would be adjusted upward or downward.

Review of prior utilization might not be a useful tool over the long term, when a majority of a health plan's Medicare enrollees will have been enrolled for many years. Should biased selection prove to be a serious problem even when enrollment has stabilized, then measures of health status could be considered. These are not ready for use at present, but if development were pursued now, health status adjustments may be available when needed. Alternatively, Medicare could pay private plans a blended rate using both the current formula and an adjustment for current utilization. Although this would reduce plans' incentives to limit utilization, some argue that this would be desirable from the perspective of the quality of care.

Other improvements in the AAPCC are recommended. The institutional status distinction should be abandoned, since institutionalization is more reflective of medical and social decisionmaking and the supply of nursing home beds than of health status. Abandoning this factor would also permit the use of more recent data to update the AAPCC. Welfare status should also be abandoned, since the category includes a heterogeneous mixture of beneficiaries categorically eligible for welfare and those who are medically indigent—eligible as a result of a major illness. The geographic unit should be broadened from the county to three-digit zip codes. The latter are more likely to reflect medical care delivery patterns and the consolidation would be particularly valuable in rural areas.

Although we recommend continuation of payment at 95 percent of a refined AAPCC for the present to maintain substantial incentives for enrollment in HMOs and CMPs, once enrollment becomes substantial, a different method of pricing would be desirable. If private health plans should become the "mainstream" delivery mode for Medicare, then payment rates should be based on typical private health plan premiums rather than fee-for-service experience. Those continuing in traditional Medicare would then pay an additional premium or receive a rebate. Alternatively, the capitation rate could be based on historical fee-for-service costs, updated by a formula.

RESEARCH AND DEMONSTRATIONS

Research and demonstrations should be an integral part of increasing the use of private health plans in Medicare. For research, the highest priority should be given to a broad program evaluation of the Medicare experience to date. It should focus on biased selection, cost experience, the quality of care, and marketing practices. Other research includes general research on health plans, development of instruments to measure health status for reimbursement purposes, and development of quality control measures for HMOs.

Demonstrations are a particularly powerful but expensive and time consuming tool. They should be reserved for large policy changes where the uncertainty about effects is too large to responsibly implement the change on a widespread basis. Since competition among health plans is an important aspect of the private health plan option strategy, the general approach of demonstrations should focus on market areas rather than individual health plans. Thus, a regulation would be changed for some market areas but not others. Highest priority policy changes to demonstrate are elimination of premium and profit regulation and capitation payments to employment-based health plans.

ADDITIONAL PRIVATE HEALTH PLAN OPTIONS

Aside from the strategy of increasing enrollment in HMOs and CMPs, some have advocated geographic capitation and use of PPAs. Geographic capitation involves making a fixed payment to an intermediary or carrier to cover the costs of all Medicare beneficiaries residing in a designated area. The insurer would have to offer a plan similar to traditional Medicare along with an array of alternative delivery systems.

Although the insurer would have incentives to review claims more thoroughly, the major potential of geographic capitation lies in the efforts of the insurer to offer attractive and efficient managed care alternatives, and to entice large numbers of beneficiaries to use them, especially the chronically ill. On the other hand, contracting arrangements of this type are extremely difficult to do well and are subject to significant political interference. The arrangement would be of most interest to already dominant insurers, and a reduction in competition in the area is a cause for serious concern.

PPAs are coming into increasing use in employment-based plans and would be feasible in Medicare. A Medicare PPA would save money for beneficiaries using preferred providers and perhaps would reduce program outlays as well. But Medicare PPAs would have somewhat less potential than employment-based PPAs. First, Medicare

already benefits from substantial discounts from providers' usual prices, particularly in hospital care, so the potential for additional savings is limited. Medicare physician payment, with its participating physician category, already has important elements of a PPA in place and working. Second, Medicare is likely to have less flexibility in choosing a panel of providers than a private PPA. It presumably would have to limit the panel to those with the lowest prices, limiting the attractiveness to consumers.

A Medicare PPA could deal with some of the problems in PPS associated with administered prices. A PPA could give beneficiaries incentives to use hospitals willing to provide care for rates below those set under PPS. This would not only afford beneficiaries the opportunity to save money on hospital care but increase the pressures on hospitals to contain costs by channeling patients into those with the lowest costs.

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CONTENTS

I. INTRODUCTION

During the early 1980s, the Reagan Administration and Congress agreed on important changes in Medicare, indeed the most important changes in the program's 20-year history. To slow the increase in Medicare expenditures, the Administration and Congress launched a two-pronged attack.

Under the first method, which we will call the "federal approach" or "fee-for-service Medicare," the federal government continues to serve as the primary health insurer for senior citizens. The federal government bears the insurance risk and manages assorted cost-containment efforts. Cost containment focuses on making Medicare a "prudent purchaser" of health care services on behalf of its beneficiaries and the taxpayers.

In its effort to make Medicare a more effective purchaser, the federal government has expanded coverage for potentially lower-cost "substitute" services (for example, hospice care), has established the prospective-payment system for hospitals (PPS), has subjected medical decisions to scrutiny by peer review organizations (PROs), and has established a "participating physician" program that uses market forces to encourage physicians to reduce their charges to beneficiaries. We call this series of reforms "the federal approach" because of the federal government's extensive role in deciding what to pay for and how much to pay.

The other approach, which we call "the private health plan option (PHPO) approach," shifts responsibility for underwriting financial risk to private health plans. Under this approach, the federal government gives Medicare beneficiaries the opportunity and incentive to use their Medicare entitlement to enroll in private health plans. Along with the financial risk, the federal government shifts responsibility for decisions about how to spend health care dollars, including decisions about appropriate medical practice and provider payment. The essence is to decentralize those complicated and often subjective decisions.

Although Congress authorized the PHPO approach in 1982 (Tax Equity and Fiscal Responsibility Act of 1982—TEFRA), regulations implementing it were not published until January 1985. In April 1985, the federal government actually began making capitation payments to health maintenance organizations (HMOs) and competitive medical

plans (CMPs).[1] Medicare beneficiaries are not required to enroll in an HMO or CMP; all beneficiaries retain the right to remain in the traditional Medicare program or to return to the traditional program on short notice.

The Administration believes that the PHPO approach will, in the long run, prove more effective than the federal approach. By making capitation payments to alternative delivery systems such as HMOs and CMPs, the federal government harnesses private innovations in health care finance and delivery for the benefit of senior citizens and taxpayers. Capitation has potential because it grants private health plans maximum flexibility to organize the delivery of health care, subject to an overall resource constraint. Arrayed against this, however, are the frictions of adding another element to Medicare—choice of a private health plan by 29 million beneficiaries, and some questions concerning the quality of care.

VOUCHERS

The expression "Medicare vouchers" is often used to refer to the PHPO approach, but there is little consensus on its meaning. Used literally, "voucher system" denotes three changes in how Medicare pays for health care services. First, a voucher system would convert Medicare from the current fee-for-service entitlement to a lump-sum payment. Second, Medicare beneficiaries would use the lump-sum payment to purchase private insurance in lieu of Medicare coverage. Third, the lump-sum payment would be in the form of a voucher—that is, script analogous to food stamps.

The first two elements of this definition are far more significant than the third. As described above, converting Medicare from a fee-for-service entitlement into a lump-sum subsidy for private insurance has important implications for the government, for health care providers, and for Medicare beneficiaries. Not least of these is that key decisions about appropriate medical practice and provider reimbursement would be decentralized, delegated in effect to private health plans. In contrast, the form of the transfer payment—whether food-stamp-like vouchers or an electronic transfer of funds—is an administrative issue.

Not everyone uses "voucher system" in the literal sense. Indeed, there is little consensus on the term's meaning. To some people, the

[1]A CMP is a term used for all private health plans that qualify under the provision but are not federally qualified HMOs. CMPs must be at risk and provide physician services *primarily* through employees of the organization or through contracts with individual physicians or groups of physicians.

term "voucher system" suggests *requiring* Medicare beneficiaries to enroll in a private health plan—that is, denying beneficiaries the option of electing fee-for-service payment in lieu of the voucher. Others use the expression "mandatory voucher system" to describe such an arrangement.

Nor is there consensus on the characteristics a private health plan must have to qualify as a recipient of the voucher. Most people agree that some minimum requirements are necessary. Without some controls, government funds could be squandered on inappropriate plans or plans unable to meet their obligations. Beneficiaries left without appropriate insurance would likely turn to government for protection in the case of illness. Government could then end up paying twice for the care of a given beneficiary.

"Voucher system" has also been applied to arrangements where there is no voucher, at least not in the literal sense of the term. This broader usage focuses on the first two elements listed above: A "voucher system" gives Medicare beneficiaries the option of taking their benefits in the form of a lump-sum payment that can be applied toward the premium of a qualified private health plan. By issuing vouchers redeemable by private health plans, the government shifts insurance risk and the responsibility for determining appropriate medical practice and how individual providers should be paid.

This report discusses "vouchers" in the latter, broadest sense. However, we will use the terms "private health plan option" and "private option" in lieu of "vouchers." "Vouchers" has assumed negative political connotations. In some quarters, "vouchers" conjures up visions of a system offering few protections to Medicare beneficiaries, who are forced to fend for themselves in the marketplace. Under this extreme view, government would not regulate the plans accepting the vouchers, as it does plans participating under the Federal Employees Health Benefits Program and as most private employers do plans enrolling their employees. For reasons discussed in following sections, this extreme form of voucher system would be unsound and politically unacceptable.

As the name implies, a private option system gives Medicare beneficiaries the option of remaining in fee-for-service Medicare. In Sec. IV, we analyze the advantages and disadvantages of a mandatory system.

PLAN OF THIS REPORT

This report analyzes how HCFA can expand the role of private health plans in serving Medicare beneficiaries. The next section considers in detail the rationale for such a strategy. After discussing the philosophical rationale for the private option approach, it compares its potential for long-run cost containment with the federal approach.

Section III describes the TEFRA provisions authorizing capitation payments to HMOs and CMPs. It argues that although not perfect, these provisions include the most important elements of the PHPO approach and of Medicare vouchers.

Sections IV–VI review various options for reforming TEFRA. The first section includes options to deregulate the use of capitation in Medicare and to extend capitation into additional areas. Section V is devoted to refinements to current policies, though these changes would also be relevant to a deregulated capitation program. The options include both steps to reform TEFRA in the direction of the purer "voucher" proposals and potential improvements relevant to all methods of capitation payments. Section VI is devoted to reforms in the setting of capitation rates. Section VII considers possible research and demonstration projects relevant to the PHPO strategy. Section VIII is devoted to two alternative private health plan approaches not generally labeled as "capitation" or "vouchers"—preferred provider arrangements (PPAs) and geographic capitation.

II. RATIONALE FOR MEDICARE PRIVATE OPTIONS

This section discusses the concepts behind the Medicare PHPO approach and contrasts it to the federal approach. Of course, the PHPO approach would not accomplish much (or would make things worse) if the private plans resembled Medicare too closely. Enrollment in those private plans labeled "alternative delivery systems" is regarded by advocates of the PHPO approach as holding the greatest potential.

DEFINING "ALTERNATIVE DELIVERY SYSTEM"

Although Medicare could in theory offer capitation payment to any private health plan that met basic requirements as to minimum benefits and financial solvency, the most significant potential comes from private plans referred to as "alternative delivery systems."

The essence of an ADS, as we use that term, is that it provides services through a select group of health care providers under contract. ADS enrollees therefore must seek health care services from these providers or suffer some financial penalty. Often, the enrollee is liable for the entire cost of services rendered by nonparticipating providers. This is called a "lock in."

The nature of the provider/ADS contract may vary. Physicians, for example, need not be employees of the ADS or members of a group practice; they may be paid on a fee-for-service basis, perhaps subject to some sharing of financial risk or agreement to seek prior approval from the ADS before admitting a nonemergency patient to the hospital or prescribing major procedures. Physicians and other providers may contract with more than one ADS.

We contrast our concept of an ADS with another type of private plan—traditional health insurance. The latter does not restrict choice of providers. Control of service volume, if any, is through patient cost sharing rather than incentives to providers. Control of prices tends to be limited to fee screens designed to limit payments to providers with charges greatly in excess of the norm, and patients are often liable for the difference between the billed and the allowed charge.[1] Claims

[1]Fee screens undoubtedly affect volume of services as well, but researchers do not agree on the direction, let alone the magnitude, of these effects—at least within the current range. Lower fee screens affect patient demand in two ways. They reduce

review functions focus on whether the service is covered and was actually performed rather than on the appropriateness of the treatment. Such traditional insurance plans will find it difficult to hold costs below those of Medicare, especially when the latter is driven by intense budget pressure to use its market power to reduce rates of payment to providers.

THE RATIONALE FOR THE PHPO APPROACH

The rationale for the PHPO approach is based on the subjective and personal nature of many medical decisions. Many laymen believe that medicine is an exact science, that for each set of symptoms there is a single, scientifically derived standard of practice. That is not the case. Humans are far too complex for medicine to be reduced to a series of iron-clad rules.

That is not to say that modern medicine is a primitive art, as some of the profession's sharpest critics would have it. Much has been done to assure that day-to-day medical practice is based on the best available scientific information. Nevertheless, physicians will never be free of the shackles of uncertainty. Medicine is inevitably a probabilistic science.

Even if scientific uncertainty were greatly reduced, appropriate medical practice could not be reduced to a cookbook. The best course of treatment often depends on the personal preferences and circumstances of individual patients. Patients have different attitudes toward risk and different levels of tolerance to discomfort. Similarly, patients have different values and opportunities regarding dependence on family and friends. These are only a few of the factors that physicians and patients must consider in selecting the appropriate course of treatment.

Because of medicine's uncertain, subjective, and highly personal character, health care providers and their patients should be granted maximum flexibility to determine the appropriate course of treatment. Political institutions are ill-equipped to make such decisions, either directly or indirectly through prescriptive payment rules.

Of course, government, as a third-party payer, is reluctant to grant providers and patients complete freedom to determine which services are needed. Taxpayers are unwilling to pay the resulting bills. Therefore, a balance must be struck. Discretion must be granted but exercised within a broad economic constraint. By making capitation

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patient coinsurance but increase additional patient liability for those services on which physicians do not accept assignment. The level of fee screens may also affect physician behavior.

payments to private health plans, Medicare establishes such a framework.

Making capitation payments to private health plans is starkly different from the federal approach as embodied in Medicare's prospective-payment system for hospitals. Both use economic incentives to influence behavior, but the prospective-payment system risks a deeper intrusion into medical practice. By classifying patients into diagnostic groups, the prospective-payment system requires federal decisions that directly affect medical practice—for example, whether to adjust the Diagnosis Related Group (DRG) weights and classifications to accommodate changes in technology or medical practice. Of course, setting the level of the capitation payments will also affect medical practice, but providers will have more latitude to adjust to the level of resources available.

By decentralizing decisions, the PHPO approach may also help assure that the amounts paid to individual physicians and hospitals are fairer than under the federal approach. The Medicare prospective-payment system, for example, bases payment on broad diagnostic and hospital categories. The system's premise is that variation in patient costs within the diagnostic categories will average out. Where there is reason to doubt this, adjustments are made by hospital type—for example, for teaching hospitals or hospitals having a disproportionate share of low-income patients.

The prospective-payment system uses broad diagnostic and hospital categories for the sake of simplicity and because the information needed for finer adjustments is not available. Judging from their efforts to alter the system, many hospitals and physicians believe the broad categories do not address their legitimate needs.

By making capitation payments to private health plans, the federal government can delegate the responsibility for allocating available resources. Private health plans will often have access to information about its patients and participating providers, much of it subjective, that is unavailable to the federal government or not usable by it. Private health plans may also adjust the payment to reflect local market conditions—for example, paying less to physicians in a particular specialty because of a local glut. Although the federal approach could attempt to do this as well, the need to pursue this in a more systematic fashion, and the resulting heavier data requirements, would limit its use.

Decentralizing decisions on appropriate medical practice and payment cannot assure that every patient and provider will be satisfied. As crude as the government's information is, some private health plans have even less. But decentralization does grant patients and physicians some added protection.

If, for example, a hospital believes a private health plan pays too little or does not meet minimum quality standards, it may refuse to deal with the plan. Under the federal approach, that may not be a realistic option. Medicare accounts for such a large share of the market that few providers can afford to refuse to participate. Each private health plan, in contrast, has but a fraction of Medicare's current market share, making withdrawal a legitimate option. From the provider's perspective, this is less coercive and more consensual than the federal approach.

Similarly, patients who are dissatisfied with a private plan's decision may complain directly, always with the implicit threat of disenrollment. The disenrollment option is likely to be far more effective in redressing problems than the political process.

ASSESSING THE POTENTIAL OF ALTERNATIVE DELIVERY SYSTEMS

As discussed above, we believe ADSs are more likely than traditional insurers to offer an attractive alternative to the traditional Medicare program. To further analyze the merits of ADSs, we discuss their likely success in specific aspects of cost containment:

- Reducing hospital admissions,
- Reducing resources per hospital admission,
- Reducing the price paid per unit of hospital resources,
- Reducing the use of physician resources, and
- Reducing the amount paid per unit of physician resources.

The potential of ADSs will be compared to what is likely to be achieved through the other approach to Medicare cost containment: the federal approach, consisting of a mixture of prospective payment for hospitals, PROs, and physician payment reforms.

Hospital Admissions

Many ADSs significantly reduce hospital admissions compared to the rate under traditional insurance plans. Prepaid group practice (PPGP) HMOs, in particular, have a well-established track record. The extensive literature on prepaid group practice suggests that they have admission rates about 40 percent lower than traditional insurance plans (Luft, 1981). The RAND Health Insurance Experiment, though including only one HMO, found a comparable experience for a group of randomly selected nonaged families (Manning et al., 1984).

One explanation of HMOs' success is that physicians in prepaid group practice are paid in ways that do not promote, and may discourage, excessive hospitalization. Another factor may be that some HMOs limit the supply of available hospital beds. Still another factor might be self-selection by physicians; physicians electing to practice in an HMO may be predisposed to the "conservative" practice style used by such plans.

Less is known about HMOs that are not prepaid group practices. Research in the 1970s suggested that independent-practice-association (IPA) HMOs were less successful in reducing hospital admissions (Luft, 1981). More recent evidence, however, suggests that IPAs have made considerable progress. The Boston Consulting Group, using federal data, estimates that IPA hospitalization rates have dropped nearly 30 percent during the last six years (Schlesinger, 1985).

Competition from other HMOs, including prepaid group practices, is forcing IPAs to reduce hospitalization to remain competitive. To reduce hospitalization, many IPAs are abandoning fee-for-service payment to primary care ("gatekeeper") physicians in favor of making a capitation payment to the physician. Many IPAs also require prior authorization for all nonemergency hospital admissions and some expensive outpatient tests. Unless the admission or test is approved in advance, the IPA will not pay the resulting bill. Many IPAs also require that some surgical procedures be performed on an outpatient basis unless otherwise authorized.

The federal approach currently does not use economic incentives to discourage excessive hospitalization. On the contrary, many observers believe that Medicare's prospective-payment system for hospitals and its physician-payment system encourage hospital admissions. Physicians tend to be paid more per unit of time for inpatient visits than for outpatient visits. Similarly, a hospital often receives more for inpatient surgery than it would for the same surgery performed on an outpatient basis, though the surgeon's reimbursement is usually the same. Neither physicians nor hospitals are at financial risk for excessive admissions.

Medicare attempts to offset these incentives by making payment for many admissions contingent on prior authorization by PROs. Although PROs are descendants of the Professional Standards Review Organizations (PSROs) that were not terribly effective (CBO, 1979), PROs do have a more manageable job: Since prospective payment establishes strong incentives to reduce the average length of stay, PROs may concentrate their efforts on reducing admissions.

Medicare admissions have declined since the advent of PPS, with the decline accelerating in the fourth quarter of fiscal year 1984

(Secretary of Health and Human Services, 1985). Admissions in fiscal year 1984 were 1.7 percent lower than in fiscal year 1983—in contrast to an average annual *increase* of 4 to 5 percent from fiscal year 1978 to fiscal year 1983. For the first half of fiscal year 1985, admissions declined 5.1 percent. Although it is difficult to identify the causes of this reversal, PROs, which began operation toward the end of fiscal year 1984, may have been a factor.

Nevertheless, we doubt that PRO review can be as effective as ADSs in reducing hospital admissions for Medicare beneficiaries. First, ADSs can establish more stringent standards for their physicians. ADS standards are not subject to the same legal and political constraints as PRO standards.

Because of its size and government's direct role in decisionmaking, fee-for-service Medicare will likely be forced to accept something approaching the lowest common denominator in admission review. To put it another way, the federal government will find it difficult to impose an admission standard that is rejected by a significant minority of physicians. An ADS, in contrast, may refuse to contract with that minority without the risk of Congressional hearings or charges that the ADS has violated Sections 1801 and 1802 of the Social Security Act. Those sections guarantee that the federal government will not interfere with the practice of medicine and that Medicare beneficiaries will have a free choice of health care provider.

Another reason ADSs are likely to be more effective than PROs in reducing admissions is that ADSs, unlike PROs, are subject to continuous competitive pressure. The marketplace is littered with the hulks of ADSs gone bankrupt or disbanded because of their failure to reduce admissions. Medicare's PROs, on the other hand, face a less immediate threat: that they will lose their Medicare contract if they do not perform. The federal government's record at disciplining poor suppliers (for example, defense contractors) warrants skepticism concerning the risks faced by PROs, although HCFA has at least initially been quite aggressive in pressing PROs to meet their contractual obligations. Although PROs will almost certainly be more effective in reducing hospital admissions than the predecessor PSROs, they are unlikely to be as effective as well-managed ADSs.

One other potential tool for reducing hospital admissions bears mentioning: patient cost sharing. In theory, this tool is available to both ADSs and fee-for-service Medicare, but in neither case is it likely to be important. The Congress has shown a strong disinclination to increase Medicare deductibles and coinsurance. Even if this were to change, a large portion of any increase (roughly 75 percent) would be paid not directly by the patient but by private Medicare supplemental insurance ("Medigap" insurance) or Medicaid.

ADSs generally do not use large deductibles or coinsurance to deter use. Indeed, they do the opposite. Most ADSs attract enrollees by offering a combination of comprehensive benefits and low out-of-pocket costs.

Hospital Resources per Admission

It is not clear whether the ADS approach or the federal approach has the greater potential for economizing on hospital resources per admission. Both have substantial tools to keep the amount paid low.

The chief tool under the federal approach is the prospective-payment system, an administered-price system that pays hospitals a fixed amount per admission based on the patient's diagnosis. This system gives hospitals a strong incentive to reduce costs under their control (including the costs of nursing, dietary services, and housekeeping) and to encourage physicians to order fewer ancillary services.

Thus far, PPS appears to have been very effective in reducing costs per admission. Hospitals have cut lengths of stay sharply. The increase in hospital operating margins has encouraged the Administration and the Congress to set payment rates for 1986 and 1987 far lower than had been expected when the program was enacted.

But there may be limits on the government's ability to keep Medicare's payments low in the long run. By moving rapidly toward national rates, many hospitals are likely to soon find it hard to break even at the PPS rates. Their complaints may cause at least a pause in the pressure of low rates. The crudeness of the DRG classification system will also limit the pressure that can be applied to rates, though refinement is likely over time.

Since PPS lacks a mechanism to steer patients to low-cost hospitals, high-cost hospitals may be successful in keeping payment rates high. To increase its market share under PPS, a hospital must do what it has always done: increase the quality of service and amenities offered to physicians and patients. The prospective-payment system does not promote price competition; quality/amenity competition remains the dominant force.

The prospective-payment system establishes incentives for hospitals similar to those faced by airlines before the deregulation of airline fares. Before deregulation, the Civil Aeronautics Board (CAB) imposed a floor on airline fares, effectively eliminating price-cutting as a way to attract more passengers. Airlines therefore competed for passengers by offering more frequent flights and more "frills": better food, in-flight movies, and so on. The CAB then ratified the nonprice competition by basing future rate floors on industrywide cost levels (Enthoven and

Noll, 1984). By the same token, hospitals wishing to fill their empty beds (average occupancy is about 65 percent) must pass on to physicians and patients some of their profit under prospective payment through offering improved services and amenities—for example, better equipment for physicians and better rooms and meals for patients.

Medicare's fraud and abuse prohibitions reinforce the tendency toward quality/amenity competition among hospitals. According to most experts, the fraud and abuse laws prohibit hospitals from making cash payments to patients and physicians to attract more business. The fraud and abuse laws establish, in effect, a small-scale barter economy in which services and amenities serve as the mode of exchange. By restricting direct sharing of profits, the fraud and abuse laws inhibit the free flow of resources out of the hospital sector, promoting inefficiency.

The Medicare fraud and abuse laws may also prevent hospitals from using their profits under PPS to pay cash rewards to physicians who reduce costs through judicious use of ancillary services. This restriction would also make it more difficult for hospitals to control the resources going into each case.

As the resulting quality/amenity competition runs its course, the resources consumed per hospital admission will fall less rapidly than they would have otherwise. The net effect on resource consumption will depend on how hard the government pushes down on the prospective-payment rates. If the government squeezes the rates, resources per admission may fall, notwithstanding the quality/amenity competition. But the government's ability to squeeze the prospective-payment rates will be constrained by the quality/amenity competition. As new services are adopted, they will become intertwined in prevailing notions of what constitutes "appropriate hospital care." Once that occurs, government will find it difficult to muster political support for squeezing them out of the system.

ADSs do not face the same constraints. They can control costs per admission both by directing patients to hospitals with low costs and through the actions of ADS physicians who order the ancillary services for ADS patients. Direct incentives to physicians may be more effective at changing practice patterns than indirect pressure through hospitals.

Hospital Price per Unit of Resource

Both fee-for-service Medicare and ADSs are able to obtain a favorable price from hospitals (relative to amounts normally charged) for each unit of service. Medicare accounts for almost 40 percent of total hospital revenues. Medicare's market power permits it to obtain favorable prices simply by offering hospitals an "all or nothing" deal: Either serve Medicare patients at this price or do not participate in the program. Hospitals financed under the Hill-Burton program do not even have the option of not participating in Medicare.

Until 1983, Medicare's all or nothing deal was based on Medicare's definition of "reasonable costs." The federal government forced hospitals to grant discounts by excluding certain items from the definition of "reasonable costs"—for example, a return on the equity invested by not-for-profit hospitals. By the early 1980s, Medicare's "reasonable costs" were 23 percent lower than hospital billed charges (Ginsburg and Sloan, 1984).

Under the prospective-payment system, the government may be able to extract an equivalent or greater discount relative to billed charges. During the system's first two years, however, Medicare payments have actually increased as a percentage of billed charges. For the program's third year, rates will be raised only 1.15 percent, an action responding, at least in part, to Medicare's payments increasing relative to charges (and costs).

An ADS's ability to obtain discounts stems from its power to channel patients to particular hospitals, not from its overall market share. It is difficult to determine whether the market power of ADSs will ultimately approach the government's. In some areas, principally rural areas and small cities, hospital competition may be too weak for ADSs to negotiate low prices. Even in large areas, it remains to be seen whether ADSs can achieve lower rates through selective contracting than Medicare can with an administered price.

In the short run, limited market power will not reduce an HMO or CMP's ability to offer an attractive alternative to Medicare patients. Current law permits (but does not require) HMOs and CMPs to use Medicare's prospective-payment system to pay hospitals for care given to senior citizens, giving them the best of both worlds.

Volume of Physicians' Services

The ADS approach will probably be more effective than the federal approach in reducing the volume of physician services per Medicare enrollee. Since the mid-1970s, Medicare has experienced large

increases in services per enrollee. A recent analysis of HCFA data found that services per enrollee grew at about a 7 percent average annual rate from 1975 to 1983 (Juba and Sulvetta, 1986).

The Medicare payment reforms now under consideration probably would not solve this problem. The most likely change is to replace the current system of "reasonable, customary, and prevailing charges" with a fee schedule, perhaps one that pays relatively more for "cognitive" services such as history-taking and physical examinations and less for technical procedures such as endoscopy. Although a change in relative fees might improve the fairness of the payment system and remove some of the distortion in signals sent to medical students selecting specialties, evidence that a change in relative fees would reduce the overall volume of services in the short run is not well established.[2] Like the current system, moreover, a fee schedule would be susceptible to unbundling—that is, the volume of billed services could increase as physicians begin to bill separately for services previously included under a single fee.

An alternative reform would be to pay for inpatient physician services per case, as is done for hospital care. Per-case payment may reduce services per inpatient case, although it would not reduce outpatient services. The chief problems with per-case payment are the amount of financial risk imposed on individual physicians and the need for major changes in the current policy on assignment of claims (Ginsburg, 1987).

Per-case payment for physicians, like per-case payment for hospitals, would depend on high-cost and low-cost cases averaging out for any given provider. For costs to average out, a provider must have a large volume and broad array of patients. A physician has far fewer patients than the typical hospital and may be more likely to treat an unrepresentative sample of patients within any given payment category (for example, diagnosis related group).

To avoid causing financial hardship, a per-case payment method must protect the individual physician from the huge potential loss associated with high-cost patients. One possible modification would be to blend per-case payment with fee-for-service payment, with the proportions varying according to the homogeneity of cases within each DRG (Ginsburg et al., 1986). Another proposal is for Medicare to stop paying individual physicians for their services, making payment instead to hospital medical staffs. The medical staff would pool payments,

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[2]One recent study found that differences between fee-for-service and prepaid group practice physicians in ordering certain common procedures varied in a systematic fashion. Differences were greater for those procedures perceived to be relatively profitable (Epstein, Begg, and McNeil, 1986).

thus spreading the risk of high-cost patients. The medical staff would also assume responsibility for determining how much each physician should receive. Granting the medical staff such power would, of course, be very controversial among physicians. Either of these modifications would dilute the incentives for efficiency resulting from per-case payment.

To make per-case payment effective, Medicare may also need to change assignment policy, possibly going so far as to prohibit physicians from billing patients (except for any deductibles and coinsurance). In other words, the government would require physicians to accept Medicare payment as payment in full. Otherwise physicians might simply bill patients on a fee-for-service basis and let patients collect the per-case payment from Medicare. Requiring physicians to accept assignment might be even more controversial than per-case payment itself—a case of "the tail wagging the dog."

ADSs will also have difficulty in controlling the volume of physician services, but they have more options and operate under fewer constraints. Physicians may be willing to enter into an arrangement with an ADS that would arouse vehement opposition if imposed by the government. If a physician decides an ADS's system is unfair, he or she can simply withdraw from the ADS. Experimentation therefore poses relatively few risks. As discussed above, refusing to participate in fee-for-service Medicare poses a different problem. Medicare's market share is so large that many physicians have little choice but to participate. Physicians are therefore understandably risk-averse about changes in Medicare's fee-for-service payment system.

Among the payment options available to ADSs are salary arrangements, profit-sharing, and capitation. ADSs will likely prefer payment systems that reward primary care physicians for appropriate medical management. Effective case management may take the form of improved medical recordkeeping, more appropriate use of referrals, more careful monitoring of medical regimens, and training family members to perform functions obviating the need for health care professionals. These activities are especially important for chronically ill patients, a group that includes many Medicare beneficiaries. Medicare's current physician reimbursement system pays little, if anything, for these important services.

Alternatively, ADSs may pursue intensive utilization review. With physician participation in an ADS a voluntary act, ADSs may be able to intrude more into medical practice than Medicare can.

Physician Fees

Both ADSs and the government are able to obtain a discount from physicians' regular fees. Medicare has long limited the fees paid to physicians, though physicians may hold the patient responsible for the full charge. In 1984, Medicare reduced 84 percent of the claims filed by an average of 24 percent. Through its new participating-physician policy, Medicare is better able to pay low rates without shifting the burden to patients. In exchange for a physician's agreement to accept Medicare's payment as payment in full for all Medicare patients, Medicare includes the physician's name in its directory of "participating physicians." Medicare may also grant participating physicians greater fee increases in future years, increasing the incentives for physicians to agree to the participating status.

Many, though not all, ADSs pay less than normal charges for physician services. By channeling patients to participating physicians, ADSs are in a strong bargaining position. It is unclear whether ADSs pay more or less than fee-for-service Medicare on average. Again, however, ADSs have more flexibility than Medicare in structuring fees. For example, ADSs may demand especially large discounts for those services in most abundant supply.

In summary, ADSs have the potential to serve Medicare patients at a lower cost than fee-for-service Medicare and will likely be competitive with the reformed Medicare program now taking shape. ADSs biggest advantage appears to be controlling the volume of services. Their ability to contain the price paid per unit of service may be comparable to Medicare's in some areas but will probably be weaker in others. The current provision allowing HMOs and CMPs to purchase hospital care through the Medicare intermediary avoids this potential disadvantage for now.

POTENTIAL PROBLEMS

The previous subsection emphasized the promise of ADSs. Potential problems exist as well. Perhaps the three most important are assuring that ADSs meet appropriate quality standards, coping with adverse selection, and marketing costs.

Quality

For years, the nation's health policy has been founded on the premise that more health care is better. Provider efforts to reduce services thus prompt concern about the quality of care. This instinctive, and understandable, bias in favor of more services has been reinforced by anecdotal evidence of poor quality in some ADSs. Perhaps the most

frequently cited examples arose out of California's ill-starred effort in the early 1970s to enroll Medi-Cal beneficiaries in prepaid health plans.

Researchers have begun to examine systematically the assumption that more services are better. There is growing evidence that the assumption is unfounded. The RAND Health Insurance Experiment found that adults and children significantly reduce their use of services when they must pay large deductibles and coinsurance, yet the decline in utilization had little detectable effect on health status (Newhouse et al., 1981; Brook et al., 1983). Among adults, the only exceptions were people with poor vision and low-income people with high blood pressure or serious symptoms (Brook et al., 1983; Shapiro et al., 1986). For those groups, increased cost-sharing and reduced utilization were associated with a deterioration in health status. Children's use of outpatient services (but not inpatient services) was affected by insurance but no health effects were observed for "typical" children. "At risk" children had some differences of clinical importance but were not statistically significant (Valdez et al., 1985). Population-based studies of variations in medical practice patterns likewise suggest that higher use does not necessarily result in improved health status (Wennberg, 1984). Such evidence suggests that costs can be reduced without sacrifices in quality.

The available evidence on HMOs is mixed but generally indicates that HMOs provide care of comparable quality to the fee-for-service sector (Ware et al., 1986). Conclusions about quality often depend on the measure of quality selected: structural measures (how many board-certified specialists), process measures (how good are patient records, are appropriate referrals made to specialists), outcome measures (how well is hypertension controlled), access to care (how long must a patient wait for an appointment), or consumer satisfaction. Conclusions on specific measures may also be affected by the type of ADS being analyzed—for example, an IPA may offer easier access to physicians than a staff-model HMO but may not coordinate use of specialists as effectively.

For better or worse, practice patterns in ADSs and under more traditional arrangements can be expected to converge in the long run. Narrowing of the differences will be the inevitable by-product of the rapid growth in the number of providers and patients electing to participate in ADSs. To continue their rapid growth, ADSs must appeal to an ever broader array of providers and an ever broader array of potential patients. As enrollment grows, ADSs must deal with providers and patients who did not join sooner precisely because they are concerned about quality. The successful ADSs will be the ones that assuage those doubts.

Although the typical ADS is likely to provide services of acceptable quality, there may be instances of plans with low quality. Under current law, the government addresses this problem by making it easy for Medicare beneficiaries to disenroll and by limiting the number of Medicare and Medicaid beneficiaries an HMO or CMP may enroll. In addition, PROs and other Quality Review Organizations (QROs) are to review the quality of care in these plans.

Particularly worrisome is the possibility that limited access to care would become apparent to beneficiaries only when illness strikes, and that a plan would be only too happy to see the those who are ill exercise their disenrollment option. Whether the aforementioned devices are sufficient, in conjunction with the threat of malpractice suits and physician ethical standards, remains to be seen. The issue of maintaining quality is discussed in further detail in Sec. IV.

Biased Selection

Another concern with the ADS approach is biased selection—that is, an ADS may enroll a sample of Medicare beneficiaries whose use of services under the traditional program would have been higher or lower than average. Biased selection could result from either patient decisions or from ADS efforts.

Published studies of the earliest Medicare HMO demonstrations showed three of four HMOs enrolling beneficiaries with lower than average rates of service use in prior years (Eggers and Prihoda, 1982). One hypothesis is that those with chronic illness are less willing to change providers to participate in an ADS. It is not clear whether different results would be obtained if a larger sample of ADSs were studied over a longer period or in a situation other than a demonstration—where patients needing more services are not discouraged from enrolling in an HMO by the possibility of not being able to obtain supplemental coverage again after the demonstration concludes.

Substantial biased selection poses risks to the Medicare trust funds. If capitation payments are based on the experience of the average beneficiary using traditional Medicare, but the average ADS enrollee would have used less than the average amount of services, then this approach will cause Medicare to overpay the ADSs. The demonstrations mentioned above indicate that the potential for overpayment is large, at least under the current payment formula.

Another problem with biased selection is that its financial impact on ADSs could overshadow the results of good or poor management of health care costs. If ADSs must risk drawing a population that has a

use rate 20 percent higher or lower than average, this will increase the business risk involved in serving the Medicare population and induce management to either devote its energies to selective marketing or avoid Medicare risk contracting altogether.

Fortunately, methods to refine the Medicare mechanism of setting capitation payments are available and hold out the hope of reducing the magnitude of the problem. They are discussed in Sec. V. However, biased selection is unlikely to be eliminated and will remain a liability of capitation systems, perhaps even their "Achilles Heel."

Of course, the problem of biased selection is not unique to capitation. In hospital prospective payment, for example, hospitals may draw a sample of beneficiaries with treatment needs that are above or below average for their DRGs. Biased selection is an affliction of all options in which payment is not based on incurred costs, and the relative severity of the problem in different payment modes is an important subject for research.

Marketing Costs

A private health plan strategy involves costs for marketing to beneficiaries that are not present under the federal approach. They may offset at least some portion of the potential cost and other advantages of the ADS approach.

Whether their magnitude will be substantial is not yet clear. To some extent it will depend on federal policy toward marketing. In private insurance, the marketing of policies to individuals and small groups is very expensive. Marketing costs of 30 percent of premiums is common. On the other hand, marketing costs in the Federal Employees Health Benefits Program (FEHBP), which are for the most part borne by the government, are much lower. Each year FEHBP supervises the preparation of uniform brochures by health plans and informs employees of which plans are operating in their locale. Although results are fragmentary, data from the Medicare competition demonstrations indicate that marketing costs per enrollee have been modest (Mathematica Policy Research, 1986). Another option that is being demonstrated by Medicare in a few areas is to have a consumer organization function as a broker to market all of the qualified plans in the area, with support from the plans and from Medicare. One factor that will tend to keep marketing costs low is renewals by existing members. All that Medicare beneficiaries must do to continue in a plan is not disenroll. As HMOs become more popular, more Medicare beneficiaries will "age in"—that is, continue in a plan as they turn 65. Unless private health plans can be marketed at low cost, much of the advantage of the strategy could be lost.

III. TEFRA SECTION 114: THE FIRST STEP TOWARD THE PRIVATE OPTION APPROACH

Section 114 of TEFRA, which authorized Medicare to sign "risk contracts" with HMOs and CMPs, began, in effect, a market test of the private option concept. If the TEFRA system proves attractive to Medicare beneficiaries and health care providers, the Congress may consider its expansion and deregulation. Section 114 thus provides an appropriate starting point for analyzing the private option concept.

THE POLITICAL CONTEXT OF TEFRA SECTION 114

Section 114 of TEFRA was the culmination of a decade-long debate on the appropriate role for HMOs in Medicare. The term "debate" is used advisedly. Many Medicare "debates" are little more than legislative battles waged among financially motivated interest groups. The HMO debate was different. Financial motives were not absent, of course, but the tone of the debate was more philosophical than usual. Beginning in the early 1970s, individual academics and private "think tanks" played an unusually prominent role. Although HMO and senior-citizen groups were active in support of the legislation, the major physician and hospital associations played little role in the debate's final stages, even though their members had much to lose from HMO penetration of the Medicare market.

Section 114 is best understood as a compromise between three groups in the Congress with distinct approaches to Medicare, groups we will call the "Medicare traditionalists," the "HMO traditionalists," and the "competition advocates." Each of the three Congressional committees with Medicare jurisdiction (House Ways and Means, House Energy and Commerce, and Senate Finance) included members of each group. Of course, many members were not closely aligned with any of the groups, and some drifted among all three.

In discussing the views of the three groups, we are admittedly oversimplifying. Perhaps no single member is a pure "Medicare traditionalist" or a pure "competition advocate." The three categories represent strains of thought as much as identifiable groups. We discuss them as groups because it highlights a key point: Section 114 is a compromise among different schools of thought about the Medicare program. Without concessions by all three groups, Congress would not have

enacted Section 114. By the same token, proponents of expanding and deregulating Section 114 must be prepared to address the concerns of Medicare traditionalists and HMO traditionalists.

The Medicare traditionalists, at least during the years before PPS, were committed to the principle that Medicare should reimburse providers for their costs and no more. Above all, the Medicare traditionalists considered themselves guardians of the Medicare trust funds against fraud and assorted special interests. Like most of their colleagues, the Medicare traditionalists viewed the ongoing inflation in Medicare costs with alarm, but few traditionalists considered economic incentives the best tool for stemming that inflation. For economic incentives to work, an opportunity for providers to earn profits on Medicare patients would have to be given—something the Medicare traditionalists did not favor. They were more likely to favor limits on maximum allowable costs and review by PSROs.

The HMO traditionalists were supporters of the HMO concept—that is, organizations providing comprehensive health benefits in exchange for fixed periodic payment. Many (though not all) HMO traditionalists were political liberals with close ties to organized labor. They viewed HMOs as the embodiment of the ideal health care system, because out-of-pocket payments would not be barriers to consumers seeking needed health care. HMO traditionalists supported close regulation of HMOs—for example, extensive mandated benefits and community rating—even if that meant handicapping HMOs in the competitive marketplace. Rather than emphasize the role of HMOs in stimulating price competition, HMO traditionalists were inclined to emphasize their role in eliminating out-of-pocket costs as a barrier to access to health care.

The competition advocates, in contrast, were anything but traditional. They were few in number and had comparatively little experience with Medicare issues. Although there were competition advocates in both Congress and the Reagan Administration, there was only sporadic cooperation between the two groups. By 1982, when TEFRA was enacted, the Congressional competition advocates had become frustrated with the Administration's failure to submit a comprehensive set of proposals for reforming Medicare.

The goal of the competition advocates was to introduce market economics into Medicare policy. For competition advocates, it was axiomatic that providers should be "at financial risk"—that is, low-cost providers should earn a profit and high-cost providers should bear a loss. They also believed consumers should be given incentives to use fewer services and to seek out low-cost providers. Unlike the Medicare traditionalists, the competition advocates viewed cost reimbursement

as the root of Medicare's problems. Unlike the HMO traditionalists, the competition advocates considered HMOs not as an end in themselves but as a means to an end—namely, introducing incentives for efficiency and price competition into the health care market.

Because they feared risk contracts would allow HMOs to reap windfall profits at the expense of the Medicare trust funds, the Medicare traditionalists had long opposed paying HMOs a fixed amount without regard to actual costs. On several occasions, the Medicare traditionalists had turned aside efforts to authorize risk contracts with HMOs, notwithstanding the incumbent Administration's support for risk-contract legislation. As the 1980s began, the Medicare traditionalists and HMO traditionalists appeared stalemated. Unfortunately for the HMO traditionalists, the Medicare traditionalists had the inertia of the status quo on their side.

In 1972, the Congress did enact legislation authorizing Medicare to sign "risk contracts" with HMOs, but the potential for HMOs to profit was limited; Medicare payment remained closely related to the HMO's costs. The 1972 legislation also required retrospective adjustments in Medicare payment, requiring HMOs to account for their costs in a manner inconsistent with normal HMO operations. Only two HMOs signed risk contracts under the 1972 legislation.

For years, the Medicare traditionalists were unwilling to go further than the 1972 legislation because they feared HMOs would reap undue profits in two ways. First, the most efficient HMOs had actual costs 10–20 percent lower than Medicare's average per capita cost. Thus, a capitation system based on average per capita costs would result in large profits for some HMOs and an increase in Medicare outlays. If HMOs were willing to provide care for less than the average per capita cost, many Medicare traditionalists considered it imprudent for the government to pay them more. The Medicare traditionalists' second concern was that HMOs would benefit from "preferential selection." In other words, some HMOs might provide care at a cost less than Medicare's capitation payment because they enrolled beneficiaries needing few health care services, not because of the HMO's efficiency.

Many Medicare traditionalists also feared that capitation contracts would cause HMOs to limit access to needed health care. Medi-Cal's ill-starred experiment with prepaid health plans in the 1970s was often cited as evidence of the risk.

Unlike the Medicare traditionalists, the competition advocates did not object in principle to HMOs profiting from Medicare patients. Far from it. In their view, the lure of profit and fear of loss were essential for a sound payment system. Most competition advocates acknowledged that some HMOs would reap profits because of preferential

selection or by denying needed services. They believed, however, that the risks were manageable and worth running. Some competition advocates even viewed new legislation as a way to prod the Department of Health and Human Services (HHS) into more focused research on risk-payment formulas. They were frustrated at the limited progress made during the 1970s and believed HHS would undertake the necessary research only after HMOs began enrolling large numbers of Medicare beneficiaries. Only then would the issue be elevated out of the realm of research and into that of budget control.

The most significant difference between 1982, the year of TEFRA, and 1972 was the growing interest in "market-oriented" solutions to public policy problems. Not the least of the changes in the political climate was the election of a conservative President committed to free-market principles. Although not all of the competition advocates were Reagan supporters (some were Democrats), his election gave political impetus to the view that market competition and economic incentives could slow health care inflation. As the competition advocates were soon to discover, however, they could not carry the day against the Medicare traditionalists by themselves. To succeed, they would need a marriage of convenience with the HMO traditionalists. But to gain the support of the HMO traditionalists, the competition advocates would be required to make concessions designed to protect Medicare beneficiaries from the unrestrained free market.

The first comprehensive statement of the competition advocates' agenda was the Gephardt/Stockman bill introduced in the 96th Congress. The Gephardt/Stockman bill, in turn, spawned several offspring in the 97th Congress, the Congress that enacted TEFRA.

The competition advocates achieved a significant victory when the House Ways and Means Committee approved one of those offspring, a Medicare private option proposal sponsored by Congressmen Gephardt and Gradison. The committee approved the Gephardt/Gradison proposal after only a brief debate. The Reagan Administration endorsed the Gephardt/Gradison proposal but offered a lengthy list of "perfecting" amendments, which would have narrowed considerably the differences between Gephardt/Gradison and similar bills in the Senate Finance and House Energy and Commerce Committees.

In all likelihood, few members of the Ways and Means Committee understood that the Gephardt/Gradison proposal included much less regulation than the bills in Senate Finance and House Energy and Commerce. In fact, few may have cared, not because they favored Gephardt/Gradison, but because they recognized there would be ample opportunity in the conference committee to rectify any shortcomings.

The full House approved both the Ways and Means and Energy and Commerce bills, even though they were mutually inconsistent. The language that ultimately became Section 114 of TEFRA was drafted by the House/Senate conference committee, with much more drawn from the Senate and Energy and Commerce bills than from the Gephardt/Gradison (Ways and Means) proposal.

Perhaps the single most important event in the legislative process was the Senate Finance Committee's approval of Senator Heinz's proposal to amend the existing Medicare rules on risk contracts. Senator Heinz's success was by no means a foregone conclusion. There were two reasons to doubt his chances for success. First, the Finance Committee had long been a stronghold of the Medicare traditionalists. Second, the Heinz proposal was being offered to a budget reconciliation bill, and there was reason to fear that adverse selection against Medicare would increase, not decrease, government outlays.

With support from the Reagan Administration and Senator Durenberger, Senator Heinz succeeded, but only after agreeing to limit the rate at which HMOs converted existing enrollees from cost contracts to risk contracts, and to delay implementation until HHS certified that the new payment methodology was adequate to assure "actuarial equivalence." The exact meaning of "actuarial equivalence" was intentionally left vague. Senator Heinz argued that it meant his proposal would not increase Medicare outlays; the Congressional Budget Office concurred.

By virtue of his steadfast advocacy, Senator Heinz earned an important say in the shape of the final legislation. He used that influence to advocate a middle ground between the Medicare traditionalists and the competition advocates. Although not clearly a member of any of the three philosophical camps, Senator Heinz was perhaps closest to the HMO traditionalists. Coming from Pennsylvania, one of the most heavily unionized states, Heinz generally favored organized labor's prescription for rising health care costs: Lift the burden from consumers and place it on providers. Like labor, he considered HMOs a promising step in that direction. As chairman of the Senate Aging Committee, Senator Heinz had cast himself as an advocate of the elderly, and he was unwilling to support private option legislation that did not include substantial regulatory protection for Medicare beneficiaries. He was, however, willing to support participation by non-HMOs, so long as they met certain basic requirements.

The concerns of the Medicare traditionalists were evident throughout the drafting sessions of the House/Senate conference committee. Even though all three committees participating in the conference had approved risk-contract legislation, final approval was not a

foregone conclusion. There was sufficient uncertainty about the budget effect of the legislation that Medicare traditionalists were able to keep alive the possibility that it could be ruled out of order in a deficit-reduction bill. Medicare traditionalists were thus able to maintain some influence on the final product of the conference. On balance, that influence was used to move the legislation closer to the regulated approach favored by the HMO traditionalists.

In the final analysis, Congress enacted Section 114 because competition advocates and HMO traditionalists agreed on important issues:

- Beyond a 5 percent "up-front" reduction in the capitation payment, government should not claim any of the savings achieved by private health plans. The benefit of their efforts should inure to the plans and their enrollees.
- Private plans should bear the full financial risk of expenditures exceeding the capitation payment.
- Retroactive adjustments and cost-reporting should be eliminated.
- Beneficiaries should retain the option of remaining in fee-for-service Medicare, at least for the foreseeable future.
- Private plans should have benefits at least as comprehensive as Medicare's.
- Private plans should be required to accept Medicare enrollees on a first-come, first-served basis, without regard to health status.
- Private plans should not be permitted to disenroll or otherwise discriminate against patients for health reasons.
- The government's capitation payments should be adjusted to reflect differences in the cost of caring for patients in different actuarial groups and in different geographic regions.
- Private plans should provide services through physicians, hospitals, and other providers meeting Medicare standards.

It bears emphasis that neither the Administration nor the Congressional competition advocates argued for what might be called a "pure voucher program." Such a program would *require* Medicare beneficiaries to enroll in private plans and grant private plans complete freedom from federal regulation. Nor did the competition advocates argue in favor of issuing script (literal vouchers) to beneficiaries. The competition advocates considered a "pure voucher" unsound and politically unacceptable.

Rather than eliminate government's role, the competition advocates hoped to reshape it. They believed government could foster market

competition by imposing structure on the market for private health plans. Competition advocates even used economic concepts to buttress the case for government-mandated rules of competition. They argued, for example, that there are economies of scale in collecting and digesting information about private health plans, justifying a role for government in plan qualification. Similar arguments were cited as justifying a minimum benefit requirement and open enrollment.

Nevertheless, there were important disagreements between the HMO traditionalists and the competition advocates. In all but a few instances, the HMO traditionalists prevailed, usually with support from the Medicare traditionalists. After describing the most important features of Section 114, we will discuss some of the issues dividing the competition advocates and the HMO traditionalists.

KEY FEATURES OF SECTION 114

The purpose of this subsection is twofold:

- To explain the most important features of Section 114 of TEFRA and the implementing regulations, and
- To identify key issues that must be addressed in any future private option legislation.

For simplicity's sake, this discussion will use section numbers from the Social Security Act, not TEFRA. Unless otherwise indicated, all references to regulations are to Title 42 of the Code of Federal Regulations.

Payment Formula

Section 1876(a) requires the Secretary of HHS to annually determine a per capita rate of payment for organizations signing Medicare risk contracts. The annual per capita rate of payment is 95 percent of the "adjusted average per capita cost" (AAPCC) for each class of Medicare beneficiaries. The AAPCC is the average per capita amount HHS estimates in advance would be payable on behalf of a class of beneficiaries if the services were to be furnished in the fee-for-service sector.

To calculate the AAPCC, HHS must define "appropriate classes of members, based on age, disability status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence." HHS may "add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence."

In the regulations implementing Section 1876, HHS uses the following demographic factors:

- Age,
- Sex,
- Reason for eligibility (age or disability),
- Whether the beneficiary is institutionalized or not, and
- Whether the beneficiary is eligible for Medicaid or not.

Eligible Organizations

Section 1876(b) defines the term "eligible organization" to include federally qualified HMOs and "competitive medical plans." To qualify as a CMP, an organization must:

- Be organized under state law,
- Provide a minimum level of services,
- Be paid for its services through fixed periodic payments (except for deductibles, coinsurance, and copayments),
- Provide physician services "primarily" through physicians who are employees of the organization or through contracts with individual physicians or groups of physicians,
- Assume full financial risk for the provision of mandated services, and
- Adequately provide for the risk of insolvency.

The Congressional and HHS staff who developed these requirements agreed that they precluded participation by indemnity insurers. There was less consensus on how the requirements would affect PPAs, who contract with health care providers but give their enrollees the option of going to providers not in the preferred group. Usually the enrollee must pay higher deductibles, coinsurance, or copayments for care rendered by providers outside the preferred group.

Contract Requirements

Section 1876 establishes additional requirements an eligible organization must meet to qualify for a Medicare contract. Among other things, the organization must:

- Have 5000 enrollees or 1500 enrollees if it serves a primarily rural area,
- Have at least 75 Medicare enrollees or an acceptable plan to reach that level within two years,

- Have no more than 50 percent Medicare and Medicaid enrollees,
- Provide services through Medicare-qualified providers and physicians,
- Provide all Medicare-covered services,
- Hold an annual open-enrollment period for Medicare beneficiaries of at least 30 days duration during which enrollees are accepted on a first-come, first-served basis without regard to health status (see the discussion below of coordinated open enrollment),
- Agree not to disenroll or refuse to re-enroll a Medicare beneficiary for health reasons,
- Permit Medicare enrollees to disenroll on 30 days notice,
- Comply with HHS regulations on advertising to and enrollment of Medicare beneficiaries,
- Make services available and accessible (24 hours a day and seven days a week when medically necessary) and assure continuity of service,
- Reimburse for services provided other than through the organization if the services were medically necessary and immediately required, and it was not possible to obtain the services through the organization,
- Provide meaningful grievance procedures, and
- Maintain an ongoing quality assurance program.

Limit on Profits

If the eligible organization's "adjusted community rate" (ACR) is less than the average of the per capita payments to be made by Medicare, Section 1876(g)(2) requires the eligible organization to:

- Provide its Medicare enrollees with additional benefits (or premium reduction) of equal value to the difference,
- Accept a reduction in its Medicare payments, or
- Put the difference in a benefits-stabilization fund.

An organization's ACR is the amount it would charge if it provided the Medicare benefit package to its general membership, adjusted for the utilization characteristics of Medicare beneficiaries. Section 1876(g)(2) is designed to assure that an organization's rate of profit on its Medicare contract is no greater than its profit on non-Medicare enrollees.

The purpose of a benefits-stabilization fund is to smooth out year-to-year fluctuation in the benefits provided to Medicare enrollees under

Section 1876(g)(2). Unless special approval is granted by HCFA, Section 417.596 of the regulations limits the amount that may be placed in a benefits-stabilization fund in any given year to no more than 15 percent of the difference between the organization's ACR and the average of its per capita rates of payment. The cumulative total in the benefits-stablization fund may not exceed 25 percent of the difference between the organization's ACR and Medicare's payment rates for the subsequent contract period.

Prohibition on Cash Rebates

In effect, Section 1876(g)(2) prohibits eligible organizations from offering cash rebates or gifts as an inducement to enroll. Section 417.428 of the regulations makes this prohibition explicit.

Optional Benefits

Eligible organizations may offer additional benefits beyond those in the Medicare benefit package; unless HHS approves making the benefits mandatory, individual enrollees must be given the option of refusing those benefits. Under Section 1876(c)(2), the organization may *require* enrollees to accept and pay for additional benefits *if* HHS has approved the added benefits in advance. HHS must approve the additional benefits unless it determines that including such additional services will "substantially discourage enrollment" in the organization.

Premium Regulation/Limit on Patient Cost-Sharing

Section 1876(e) limits the amount an eligible organization may charge for coverage of the basic Medicare benefits. The organization's premium for those basic benefits plus the actuarial value of its deductibles, coinsurance, and copayments may not exceed the actuarial value of the coinsurance and deductibles its enrollees would have paid *on average* if they had not enrolled in the eligible organization. If data are not available to estimate how much the organization's enrollees would have paid under fee-for-service, HHS may estimate the actuarial value of the deductibles and coinsurance paid by the average Medicare beneficiary.

If the eligible organization provides additional benefits beyond the basic Medicare benefits, the premium for those benefits plus the actuarial value of any deductibles, coinsurance, and copayments on those benefits may not exceed the eligible organization's adjusted community rate for those services.

Marketing Restrictions

Section 1876(c)(3)(C) gives HHS broad authority to regulate marketing and enrollment. Eligible organizations must submit their marketing materials to HHS for prior approval. Section 417.428 of the regulations prohibits discriminatory marketing practices (for example, efforts to recruit only high-income beneficiaries), misleading practices, offers of gifts or payments as an inducement to enroll, and door-to-door solicitation.

Coordinated Open Enrollment

In 1984, Congress amended Section 1876(c)(3)(A) to require HHS to establish a single 30-day open enrollment period annually during which all organizations must allow open enrollment. HHS may vary the timing of enrollment period by market area. Congress authorized HHS to phase in this requirement over a three-year period. Eligible organizations will be permitted to hold additional open enrollment periods at their discretion.

Payment to Hospitals and Skilled Nursing Facilities

Section 1876(g)(4) gives eligible organizations the option of paying hospitals and skilled nursing facilities through the Medicare fiscal intermediaries using the payment formulas established under the fee-for-service Medicare program. If this option is elected, the amount of those payments plus any associated administrative costs is deducted from the organization's capitation payment.

Termination of Contract

Section 1876(i)(1) requires risk contracts to be for a term of at least one year, except that HHS may terminate a contract at any time if:

- The organization has failed to carry out the contract,
- It is carrying out the contract in a manner "inconsistent with the efficient and effective administration of this section," or
- It no longer "substantially meets" the requirements of Section 1876.

Right to Inspect

Section 1876(i)(2) gives HHS the right to inspect or otherwise evaluate the quality of services provided and the financial status of the contracting organization.

IV. CAPITATION POLICY OPTIONS: DEREGULATION AND EXTENSION

The next three sections consider options for change in Medicare policies toward capitation. The thrust is how to revise these policies so that the benefits of capitation to the beneficiaries and the taxpayers are increased. An implicit assumption behind the discussion that follows is that capitation has the potential to meet the needs of a larger proportion of beneficiaries than are availing themselves of the opportunity at present.

The broad policy choices can be summarized in three basic strategies:

- Deregulate Medicare capitation. This strategy would involve elimination of profit and premium regulation, a loosening of minimum benefit requirements, and allowing plans to offer cash rebates to beneficiaries. It would resemble the Gephardt/Gradison proposal, discussed above, and the Administration's voucher proposals.
- Broaden the capitation program to include private indemnity insurance plans, including preferred provider arrangements (PPAs). An important element of this strategy would be permitting employers to receive a capitation payment from Medicare for those eligible retirees who enroll in the employer's health benefits plan. This strategy could be seen as part of the deregulation strategy but would not require many of the other aspects of it to be coherent. Mandatory vouchers would also broaden capitation but would eliminate government-provided insurance in the process. The Administration's voucher proposals had incorporated provisions to include indemnity insurance plans under capitation and to contract with employers on a risk basis but had not called for mandatory vouchers.
- Continue the philosophy behind current policies but implement refinements. This would mean continuing to limit participation to HMOs and CMPs and regulate premiums and profits. Significant refinements might come in the area of setting the capitation rates, in the role of Medicare in marketing of private health plans and providing consumer information, and in quality assurance activities. Many of these refinements would also be relevant to the deregulation strategies.

The remainder of this section is devoted to the first two strategies—deregulation and broadening the capitation program. Section V discusses refinements of current policies and Sec. VI discusses setting capitation rates—an issue that is critical to both deregulation strategies and refining current policies.

REGULATION OF PREMIUMS AND PROFITS

Section 1876 regulates the premiums and profits of HMOs and CMPs in several ways. It limits the amount an eligible organization may charge for coverage of the basic Medicare benefits—that is, the benefits provided to beneficiaries not enrolled in HMOs and CMPs. The organization's premium for those basic benefits plus the actuarial value of its deductibles, coinsurance, and copayments on those benefits may not exceed the actuarial value of the coinsurance and deductibles its enrollees would have paid on average if they had not enrolled in the eligible organization.

It also limits the premium an HMO or CMP may charge for supplemental services not covered by Medicare. The premium for supplemental services may not exceed the HMO/CMP's ACR for those services. The ACR is the amount the HMO or CMP would charge its Medicare enrollees if it calculated its premium the same way as it does its premiums for private enrollees, with an adjustment for the higher use of health care services by the elderly. An eligible organization's ACR incorporates a rate of profit comparable to what it earns on private contracts.

Section 1876 also regulates the profit that HMOs and CMPs may earn from their Medicare contracts. If the eligible organization's ACR for the basic Medicare benefits is less than the average capitation payment received from Medicare, the difference must be passed on to the organization's Medicare enrollees in the form of expanded benefits and reduced out-of-pocket payments. Alternatively, the HMO or CMP can return the excess to the government or put it in a benefits-stabilization fund. The goal is to limit a plan's profit to the same level earned on private contracts.

The sponsors of these provisions feared that HMOs and CMPs might earn excessive profits on their Medicare contracts. The sponsors hoped, in particular, that the ACR would prevent HMOs and CMPs from reaping windfall profits resulting from preferential selection. In theory, the ACR would assure that any profits from preferential selection would accrue to the benefit of Medicare enrollees. The sponsors of the ACR were concerned, however, with more than just finances.

Some feared the lure of large profits might prompt plans to cut services inappropriately, endangering the health of Medicare patients. Because many Medicare patients might be ill-equipped to detect any erosion in the quality of care, the sponsors of these provisions were unwilling to rely on market forces to discipline HMOs and CMPs.

Adjusted Community Rate

The ACR concept is central to this system of premium and profit regulation. There are two basic steps in calculating an ACR. First, the plan must calculate its "initial rate," the premium it would charge if it provided Medicare-covered services to its non-Medicare members. That initial rate is then adjusted to reflect the difference between the amount of health care used by the plan's Medicare enrollees and the amount used by the plan's non-Medicare enrollees.

In evaluating the ACR rule, both the validity of the underlying concept and its execution must be examined.

An appealing aspect of the ACR is that the permissible profit is not some "fair rate of return" but is linked to what the HMO or CMP earns in the private market. This link lends the calculation legitimacy; in an era when "regulation" has assumed pejorative connotations, the ACR's proponents may at least claim that the ACR is "market-based" regulation. For several reasons, however, it may be inappropriate to limit an HMO or CMP's profit on Medicare business to the same rate the plan earns on its private business.

First, standard economic analysis suggests that it is appropriate for the rate of profit to increase with the amount of risk assumed. Because Medicare beneficiaries are enrolled individually, not through preformed groups, it is, at least initially, more difficult for HMOs and CMPs to predict their costs for Medicare enrollees than for their private enrollees. Some HMOs and CMPs may enroll Medicare patients with disproportionately higher costs than the same organization's private patients; some organizations may enroll "better" Medicare risks than private risks, after adjusting for differences in the overall use by the Medicare and non-Medicare population. Whatever the ultimate risk selection, however, HMOs and CMPs face considerable uncertainty at the beginning of their Medicare contracts.

The AAPCC, the formula Medicare uses to pay HMOs and CMPs, is intended to reduce the risk by adjusting Medicare's payments to reflect the risk associated with various classes of Medicare enrollees. As discussed in Sec. VI, the AAPCC is not very effective at varying payments to reflect differences in risks. It is possible that the AAPCC will systematically underpay organizations that enroll Medicare beneficiaries

needing more medical care than average; other organizations may be overpaid. For reasons discussed below, the ACR may pose a special problem for plans whose Medicare enrollees are *more* costly than average and whose private enrollees cost *less* than average.

The risk associated with enrolling Medicare patients may be compounded by many HMOs' and CMPs' inexperience in meeting the unique health care needs of senior citizens. Predicting the cost of care and calculating the appropriate premium could prove quite difficult, at least in the short run.

To compensate for these risks, it may be appropriate to permit HMOs and CMPs to earn a larger profit on Medicare business. If Medicare profits are held too low, many HMOs and CMPs will refuse to participate in the program. Those that do participate may feel compelled to protect themselves by seeking to enroll only low-risk Medicare patients. Although eliminating the ACR rule would not eliminate the incentive for plans to "skim" the best risks, the ACR rule may aggravate the problem. Under the current rules, HMOs and CMPs face an asymmetric system of potential risks and rewards. The risk from enrolling high-cost Medicare patients is unlimited; the potential profit from efficiency and effective health care management is capped by the ACR.

Another problem with the ACR rule is that it may limit the growth of HMOs and CMPs and inhibit their efforts to improve services. The problem may be especially severe for new HMOs and CMPs. Because of start-up costs, new plans are usually less profitable than older plans. If a new plan earns a low rate of profit on its private contracts, the ACR rule will, at least in theory, assure that the plan earns the same low profit on its Medicare contract. Moreover, the ACR rule will limit the plan's profit regardless of how well the plan does in reducing the health care costs of the elderly and regardless of how reasonable the plan's Medicare profit might be. Without profits, new plans may find it difficult both to expand and to add new facilities to enhance the service offered existing Medicare enrollees.

Finally, it is not clear whether the ACR concept can achieve one of its objectives—removing the incentives for unscrupulous plans to cut services inappropriately. The ACR limits *the rate of profit per enrollee* but permits HMOs and CMPs to increase their profits by enrolling more Medicare beneficiaries. Cutting the premium or offering a richer benefit package is one way to attract new enrollees. Thus, requiring plans to return to their enrollees the difference between their ACR and the amount received from Medicare does not eliminate the incentive to cut costs as low as possible. The added benefits financed from the "savings" may attract new enrollees.

On the other hand, although incentives to cut use inappropriately remain, the ACR concept makes such a strategy riskier. It requires a "high-volume" approach. Growing rapidly while providing too few services might be more difficult than serving a smaller number of enrollees while earning large profits per capita.

Execution of the ACR Concept

Difficulties in calculating the ACR may cause unintended problems, particularly for small plans. For the ACR to achieve its purpose, it must reflect an individual plan's relative costs in caring for Medicare and non-Medicare patients. Separate adjustments must be made for each of the components of the initial rate—for example, inpatient hospital expenses, skilled nursing expenses, and physician expenses. To make a valid comparison, an HMO or CMP must have many enrollee/months of data on the costs of caring for the two groups. Without sufficient data, a plan's ACR may be artificially low or high in any given year and unstable from one year to the next. If the ACR is artificially low, the plan's profit on Medicare will be less than its profit on private contracts; the plan will be required to "pass on" to its Medicare beneficiaries "savings" that it never achieved. If the ACR is artificially high, the reverse may be true.

HCFA acknowledges that many HMOs and CMPs may not have sufficient data to adjust their initial rate (the rate charged private enrollees) to reflect the higher use of services by Medicare enrollees. It therefore permits plans with new Medicare contracts to base the adjustments in their ACR on "documented statistics from a nationally recognized statistical source." After the first year of its Medicare contract, however, the regulations [417.594(c)(3)] require the plan to make the required adjustments using its own data or to permit HCFA to adjust its rates using data from other HMOs and CMPs or other sources. (At least informally, HCFA's Office of Prepaid Operations (OPO) has indicated that it will be flexible in applying this requirement. Even after the initial contract year, OPO may permit HMOs and CMPs to submit proposed adjustments based on "nationally recognized statistical source(s).")

If a plan does not have sufficient data on its own experience to calculate a valid ACR and must rely on other sources, it may face substantial risks. Assume, for example, that an HMO enrolls a disproportionate number of the high-cost enrollees within the various actuarial categories constituting the AAPCC. As a result, the amount Medicare pays the HMO will be less than it would have cost to care for those patients in the fee-for-service portion of Medicare. Unless the ACR

adjustments are calculated using data from a plan with a comparable selection of Medicare *and* non-Medicare risks, the plan's ACR may also be artificially low. The plan could then face the potentially disastrous financial consequences of two errors compounding one another. The HMO or CMP would be paid too little by Medicare and then would be required to pass on to beneficiaries nonexistent "profits." By the same token, a flawed ACR may fail to capture the "windfall profits" from a preferential selection of risks.

In other words, errors in the AAPCC and in an ACR not based on plan-specific data will frequently compound, not offset, one another if those errors result from biased selection. The ACR cannot capture windfall profits from preferential selection unless it is based on plan-specific experience. Thus, HCFA's emphasis on using plan-specific data is well-placed. The problem is that a plan may not be able to accumulate sufficient Medicare experience on which to base its ACR without going through a period when its ACR is very unreliable. Even if the ACR concept would work in the long run, an unlucky plan may be bankrupted long before then.

This problem with the ACR may be addressed, at least in part, through use of a benefits stabilization fund, as authorized in $417.596 of the regulations. Rather than requiring HMOs and CMPs to pass on to their Medicare enrollees the entire difference between Medicare's payment and the plan's ACR, HCFA permits plans to deposit a portion of the money in a benefits-stabilization fund. The fund is used to prevent excessive year-to-year fluctuation in benefits. However, because all money in the fund must either be used for increased benefits or returned to HCFA, stabilization funds cannot protect plans against consistent errors in the AAPCC and ACR.

As with all attempts to regulate profits, the issue arises concerning whether health plans can evade such regulation. Conferring inappropriate profits on suppliers is a possibility. Regulations can be evaded through owners paying themselves high salaries or inflated management fees or through purchasing services through related enterprises. Allocation of joint costs between Medicare and non-Medicare enrollees also affords opportunities to understate profits. At a minimum, HCFA will have to invest heavily in auditing to enforce regulations on profits.

Possible Changes in the ACR

HCFA has several options for dealing with these problems in the ACR concept and in its execution. Among them are:

- Repeal the ACR requirement (both the Gephardt/Gradison proposal and the Administration's voucher bill would do this).
- Exempt all HMOs and CMPs from the ACR requirement until the fifth (for example) year of their Medicare contract.
- Exempt HMOs and CMPs from the ACR requirement until their Medicare and non-Medicare enrollments, respectively, meet certain thresholds.
- Exempt HMOs and CMPs from the ACR if they face significant competition (on the theory that competition will limit their profits).
- Increase the minimum private enrollment for HMOs and CMPs to become eligible for Medicare risk contracts.
- Increase the amount an HMO or CMP may set aside in a benefits-stabilization fund.
- Permit small HMOs and CMPs to use nationally recognized data sources to justify their utilization and intensity adjustments beyond the initial contract year (for example, the ACR could be based on a blend of plan-specific and other data, with the plan-specific portion increasing as the HMO/CMP increases its enrollment).

This list of options is not exhaustive, only suggestive. Except for the last two, all of these changes would require legislation. The last option would codify what appears to be the current practice of the OPO.

To begin evaluating these options, HCFA should analyze at least five questions:

- Did HMOs participating in demonstration projects without the ACR reap higher profits than those subject to the ACR?
- How many HMOs and CMPs provide more benefits than required by their ACR or charge less than their ACR for supplemental benefits?
- How many enrollee/months of data must an HMO or CMP have to develop statistically valid and stable adjustments for the difference between the amount of services used by *its* Medicare and non-Medicare enrollees?
- Can a stable ACR be calculated using fewer data if enrollees with very high costs are partially excluded from the analysis?

- Is the ratio of Medicare to non-Medicare utilization stable across HMOs and CMPs?

So long as Congress insists on retaining the ACR (the Administration's voucher bill proposes repeal), it is inevitable that plans with new Medicare risk contracts will have difficulty calculating their ACR. Plans with little prior Medicare experience simply cannot know how their Medicare costs compare to their non-Medicare costs. Using data from ACR submissions based on plan-specific costs, HCFA could attempt to answer some of the foregoing questions.

Perhaps plans with small *Medicare* enrollments could use composite ACR adjustments, based in part on their own experience and in part on experience at similar HMOs. As the plan's Medicare enrollment increases, the blend could move in steps toward an ACR that is 100 percent plan-specific. If the ratio of Medicare to non-Medicare costs varies unpredictably across plans, it may be necessary to exempt plans with little Medicare experience from the ACR rule.

A more serious problem is posed by plans that have *neither a large Medicare enrollment nor a large private enrollment.* Instead of only one element of the Medicare/non-Medicare utilization ratio being highly variable, both may be. With both elements of the ratio subject to dramatic change, the ACR adjustment could swing wildly from year to year. Moreover, the risk from an inaccurate ACR is especially great for a small plan, particularly if Medicare patients are a high percentage of total enrollment. As described above, errors in the ACR and the AAPCC may well be mutually reinforcing and have devastating financial consequences for small plans. HCFA may therefore wish to analyze the potential benefits of requiring HMOs and CMPs to have larger private enrollments before becoming eligible for Medicare risk contracts. Under current law, eligible organizations must have at least 5000 enrollees, unless they serve a primarily rural area. Rural plans need only 1500 enrollees.

MINIMUM BENEFITS

Under current law, private health plans must provide benefits at least as comprehensive as Medicare.[1] This has not posed much of a problem for HMOs, which have traditionally operated only with relatively comprehensive benefit packages. Cost sharing is often lower,

[1]Actually, HMO benefits are required to be somewhat more comprehensive than Medicare's, because beneficiary liability for physician charges exceeding Medicare's screens is not included in the formula.

and catastrophic protection better. Preventive services—generally not covered in Medicare—are frequently provided by HMOs.

Minimum benefits could be an issue if the scope of qualifying organizations were broadened to include indemnity plans. An indemnity insurer might propose a plan that covered only catastrophic expenses, for example. Or a combined Part A and Part B deductible of $1500 per year could be offered. Or an organization could propose a plan with only limited benefits, thus permitting the beneficiary to "cash out" his or her Medicare benefits.

The argument for permitting such plans to be offered is that a wider range of choice would make the Medicare entitlement more valuable to beneficiaries without an increase in cost to the taxpayers. Many economists have long argued for the superiority of cash over in-kind benefits. Some might be better off by spending more of their income on food and housing and less on medical care, but an *in-kind* entitlement restricts opportunities for such tradeoffs. The nature of Medicare benefits often precludes any tradeoffs whatsoever; for example there is no opportunity for a beneficiary to save money by using a low-priced hospital.

Many factors argue in favor of maintaining a minimum benefit requirement similar to that under current law, however. First, opportunities under the private option strategy for beneficiaries to save money on health care already are extensive. A plan might restrict hospital admissions to low-cost hospitals, for example, and reward enrollees through a low premium. If cash rebates were permitted (see the discussion below), the opportunities to trade off medical care for other goods and services would increase further. Enrolling in a low-priced private health plan is in many cases a way to economize on medical care that is superior to purchasing insurance with substantial cost sharing, since it avoids the financial risk to beneficiaries under the latter.

Second, there are "free rider" incentives to underinsure. If an individual were to choose only minimal health insurance, but then happened to require hospitalization, the chances are good that he or she would be admitted despite inability to pay the entire bill. Other sources of funds—such as local subsidies to public hospitals and charity—would often underwrite the cost of the care. In this instance, society would pay twice for the beneficiary's medical needs.

Third, permitting plans with extensive cost sharing risks substantial adverse selection against the government. It is well established that when a choice among fee-for-service insurance plans is offered, those choosing plans with more cost sharing expect to have medical care use that is lower than average for their actuarial category (Price and Mays,

1985). Unless offset by refinements in the AAPCC (see Sec. VI), elimination of minimum benefit requirements could be quite costly to the Medicare trust funds.

Finally, one must raise the question of how many beneficiaries would opt for a plan with extensive cost sharing if they had the time and ability to fully analyze alternative plans. Given the rate at which Medicare beneficiaries purchase supplemental coverage, it may be the case that very few would find appealing plans with cost sharing much more extensive than current Medicare. If that is the case, offering such an option could do more harm than good. The number of beneficiaries inadvertently assuming much more financial risk than intended could far exceed those preferring a high cost sharing plan with full knowledge of the decision that they are making.

Such an argument may appear paternalistic to some, but it is very important politically. During hearings in 1981 on the early voucher proposals, members of Congress repeatedly raised the issue of the elderly making the "wrong" decision concerning which health plan to enroll in. The specter of constituents coming to them to complain about the financial disasters stemming from a decision to choose a plan with little financial protection was very much on the minds of the members.

These arguments in favor of a minimum benefit provision apply more strongly to the removal of all restrictions than to requiring only that catastrophic protection be maintained. Certainly the latter would limit the consequences of choosing a plan with too little financial protection. The extent of uncompensated care that local governments and privately insured persons must pick up would also be limited under a catastrophic plan. But all of the negative arguments outlined above would still apply, albeit at a reduced magnitude. The magnitude of the biased selection problem would still be substantial.

These arguments lead us to recommend that the current minimum benefit provision be maintained.

CASH REBATES TO BENEFICIARIES

Under current law, when the AAPCC is higher than the ACR, the difference must be passed on to beneficiaries in the form of reduced premiums or additional benefits. If, after reducing premiums to zero, additional amounts must still be passed on to beneficiaries, current law does not permit payment of a rebate.

The prohibition on rebates may limit the development of capitation by reducing the incentive to enroll in plans. Additional benefits may be

less attractive to beneficiaries than a cash rebate. Most common additional benefits are preventive services, outpatient prescription drugs, and dental care. In each case, insuring such services is costly because of high administrative costs relative to the size of the claims and the additional use of services induced by the presence of insurance. This gives rise to concerns that beneficiaries would be better off with a cash rebate than with additional insurance coverage.

In HMOs, however, the cost of insuring these services is likely to be lower than under traditional insurance. The administrative costs of preventive services and drugs are likely to be lower, since claims are not required. The incentives of HMO physicians may reduce the "moral hazard" problem generally associated with coverage of these items.

The reduction in incentives to enroll in HMOs caused by the current prohibition on cash rebates is unlikely to be very large. Because regular cost sharing in Medicare is substantial, those HMOs that can relieve the beneficiary of this burden and the need to pay a premium in lieu of it will already be offering a very substantial incentive to enroll. Because HMOs are in a position to provide some of the additional covered services with low administrative costs (for example, preventive services and prescription drugs), the services may be valued highly by many beneficiaries in relation to their costs. Thus, prohibition of cash rebates probably reduces incentives only slightly.

Rebates could cause some problems, however. Those plans in a position to offer substantial rebates may tend to be those benefiting from biased selection. It would not be in Medicare's interest to have those plans gain an advantage over others and have the most rapid growth in enrollment.

Rebates could make it easier for fraudulent plans or those offering the lowest quality to thrive. Many low-income persons who are already underserved in the fee-for-service system might find the offer of an up-front rebate difficult to resist even if underservice under the capitated plan is likely. This possibility might be reduced by permitting rebates to be paid only after a period of enrollment—perhaps annually except in cases of disenrollment. The Administration's proposal would not permit rebates during the first year of enrollment.

In summary, although we appreciate the efficiency that rebates would permit, we doubt that in practice the current restriction is a very significant one. Given the risks that rebates might entail, and the likely opposition from those less confident in competitive approaches, we are hesitant to recommend that changing this aspect of the law be given high priority.

DEFINITION OF QUALIFIED PLAN

Two possible changes in the definition of a qualified plan merit discussion. One would permit plans that offer an unlimited choice of providers. The second would permit an employer-sponsored plan to receive a capitation payment but limit enrollment to its employees and retirees (and allow unlimited choice of providers as well).

Unlimited Choice of Providers

Current law requires that a health plan provide physician services "primarily" through physicians who are employees of the organization or through contracts with individual physicians or groups of physicians. This provision appears to permit plans that allow beneficiaries to go outside of the panel of providers and pay additional cost sharing, so long as the total cost sharing for the particular service does not exceed that in traditional Medicare. This would include "insured PPAs." The only types of plans that appear to be excluded under current law are those offering unlimited choice with the results that physician services are not provided "primarily" through physicians under contract.

One attractive feature that private plans with unlimited choice might have (in comparison with traditional Medicare) is the integration of private supplemental coverage (Medigap) with basic coverage. Approximately two-thirds of Medicare beneficiaries are covered by private supplemental insurance—obtaining it either by individual purchase or through current or former employment. Having two policies often proves to be quite cumbersome. Claims must first be filed with Medicare and then with the supplemental carrier. A single private policy could streamline the process.

Private plans with unlimited choice could lower costs through utilization management that was more effective than Medicare's. Preadmission review could be more stringent than that conducted by the PROs, for example. Other innovations in utilization management that are being experimented with in some employment-based insurance plans could be used. Some employers have used case managers for catastrophic illness, for example. Claims review could be more vigorous than what Medicare intermediaries and carriers do in the absence of incentives.

Whether such plans could compete with Medicare is doubtful. They would face marketing costs and, unless permitted to purchase hospital care through intermediaries as HMOs and CMPs do, they would probably pay more for hospital care. Their ability to compete would come

down to how much more effective than Medicare's were their utilization and claims management activities.[2]

The argument for permitting health plans offering unlimited choice is that the market should decide whether or not they can compete with Medicare. Plans offering unlimited choice probably pose less risk of beneficiaries suffering from a poor choice than plans currently qualifying, as long as the minimum benefit structure requirements were maintained.

There are two arguments on the other side. The first is that the probability of an attractive plan arising under this broadening of the eligibility requirements is too small to devote the necessary efforts to write regulations and prepare to administer the additional types of plans. Should an attractive plan appear, a demonstration could be permitted.

The second argument concerns biased selection—that those who enroll would have used fewer services than average had they remained with basic Medicare. At first blush, the argument does not make sense. Such risks seem greatest where a change of provider is required, such as in enrolling in staff model HMOs. The concern regarding biased selection in plans that allow unlimited choice is based instead on skepticism about the ability of such plans to compete otherwise. If indeed few, if any, would be able to compete, then the only plans that would attempt to enroll Medicare beneficiaries on a risk basis would be those that expect to be able to draw a sample of beneficiaries with low expected use of services—perhaps through selective marketing.

The first argument against unlimited choice seems more compelling to us. We do not detect a clamoring of insurers or others to offer plans to the Medicare population at 95 percent of the AAPCC. With demonstration authority in place in an agency very interested in expanding the use of capitation, promising prospects can be pursued. A demonstration would not only show us whether plans with unlimited choice could compete with Medicare (and if so, how), but would bring the idea to the attention of additional organizations with such potential.

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[2]Plans with unlimited choice of provider might be faced with problems from the minimum benefit requirement if "balance billing" by physicians was counted as cost sharing (it is not counted when measuring the comprehensiveness of Medicare benefits).

Employment-Based Plans

Permitting risk contracting with employment-based plans has attractive features beyond the unlimited choice of provider option discussed above. This option would give a potentially large number of Medicare beneficiaries an opportunity to benefit from all of the innovations in health care cost containment being pursued by large employers. According to the 1977 National Medical Expenditure survey, 36 percent of aged Medicare beneficiaries receive some group insurance through a current or former employer. In addition, the administrative savings and convenience of combining basic insurance and supplemental coverage that were discussed above would apply. A discontinuity in coverage and administration upon reaching age 65 would be avoided. Finally, the employers' use of annual open seasons is likely to be a more effective means to inform Medicare beneficiaries about alternatives to traditional health insurance than the current marketing efforts of individual HMOs and CMPs.

The most important aspect of using employment-based health plans is efficiency in marketing. Large employers incur very small loading costs in purchasing health benefits on a group basis (actually, most are self insured) and in informing employees and retirees of the choices available to them. This has the potential of making many types of alternative health plans attractive to employees—types of plans that may not have been able to compete with Medicare otherwise because of the costs of marketing. In addition, large employers might be able to try innovative solutions to the biased selection problem.

Aspects beyond marketing efficiency may also contribute to the potential of capitation payments to employment-based health benefits plans. Utilization management efforts of large employers in the context of traditional insurance with unlimited choice of provider might be more effective than those of PROs. Employers can use competition to hire experts to perform review and can take much more flexible approaches to utilization management than the political process allows PROs to take.

Although many of the specific cost containment activities pursued by employers could be incorporated into health plans that differ from traditional HMOs but nevertheless qualify as Medicare CMPs, thus far few have. For example, many large employers have been experimenting with PPAs, whereas only five Medicare CMPs permit enrollees to use providers outside the panel. The small number of CMPs that resemble PPAs could be due to either or both of the following:

- Entrepreneurs are too busy developing HMO-type plans for Medicare, which may have more potential. When that market

becomes more saturated, they will start PPA-type plans to appeal to a different segment of the Medicare market.

- PPA-type plans for Medicare do not have the apparent potential that employment-based PPAs do. Alternatively, the potential of all PPAs is uncertain, but the risk-reward ratio is less favorable for a Medicare plan.

If the first reason were the case, then capitation for employment-based plans would accelerate the movement of Medicare enrollees into private health plans. If the second reason were the case, not only would acceleration result, but the ultimate role that private health plans would play in Medicare could be larger.

Two possible factors come to mind as to why PPA-type plans might be less attractive as Medicare CMPs than as options in employment-based plans. One is the various regulations discussed above, such as regulation of profits and premiums. Although such regulations could still apply to capitation payments for Medicare beneficiaries enrolled in employment-based plans, the risk in launching such arrangements has already been taken on the basis of their potential for non-Medicare employees.

The second involves marketing costs. Although the cost-containment potential of HMO-type plans may be sufficient to outweigh the costs of marketing to individuals, this might not be the case for PPA-type plans, which may have less cost-containment potential. The result could be that PPAs for Medicare beneficiaries are economically viable only as part of broad employment-based plans.

Capitation of employment-based plans also has some potential to deal with the biased selection problem. With employers receiving a capitation payment for all who participate in the health benefits program and are eligible for Medicare, they will have the opportunity to devise methods for paying HMOs and setting the terms of employee contributions to HMOs and PPAs. This potential is only theoretical at present, since private employers have not been innovative to date in dealing with biased selection in plan choice. Although the HMO Act has, through its requirements of community rating (for federally qualified HMOs), limited employers' options to deal with biased selection, few employers have taken advantage of the actuarial adjustments (e.g., age and sex) that are permitted under current regulations.

Determining the appropriate capitation rate to pay employers would require adjustments to the AAPCC. Although the selection of plans by individual employees would not affect Medicare outlays, the self-selection among employers to seek a capitation payment for their employees could increase Medicare outlays.

Health services utilization may be lower for those beneficiaries covered by employment-based plans than their cohorts who are not so

eligible. Those with employment histories entitling them to coverage for health benefits during retirement may be in better health than other Medicare beneficiaries. On the other hand, the superior health care coverage of those with such employment histories may have developed habits of higher rates of use of medical care. Utilization of health services is also likely to vary by industry on the basis of the nature of the work. For example, those with careers in mining are likely to have higher medical care needs during retirement than those in financial services.

Fortunately, data are available to make employer-specific adjustments to the AAPCC for large employers. If an employer supplied to Medicare the Social Security numbers of all Medicare eligibles participating in the health benefits plan, the program's actuaries could compare prior use to others in a matched cohort and arrive at an adjustment to the AAPCC. Such an initial adjustment could be used for many years. In the distant future (or sooner if the above method proves to be too cumbersome), methods not relying on Medicare program data might have to be employed. Perhaps tabulations of the Health Interview Survey by industry of employment for workers not eligible for Medicare would yield a crude adjustment, or data on the employer's 60- to 64-year-olds could be compared to national indicators.

Employment-based plans that received capitation payments would be subject to most other current Section 1876 regulations. For example, all of the plans offered Medicare beneficiaries would have to have benefits at least as comprehensive as those in Medicare. The maximum proportion of Medicare enrollees in HMOs might be maintained. But health plans might be exempted from Medicare qualifications regarding premiums, profits, enrollment practices, and having physicians under contract. Employers would deal with these issues, as they always have. Plans might be limited to providers meeting Medicare participation standards, however.

Some issues regarding participation would have to be explored. Many employers do not have distinct Medigap plans. Those active workers or retirees who are eligible for Medicare participate in the regular plan, which in effect "wraps around" Medicare to serve as supplemental coverage. Under a capitation agreement with Medicare, would all employees have to participate in the capitated plan? Or could some stay in Medicare if they so desired?

Most, though not all, Medicare beneficiaries would be better off under the employer's plan, so the issue would not affect many. The typical beneficiary would find the employer's basic indemnity plan similar to Medicare but would benefit from the streamlining of claims

processing. Some would benefit from incentives to use preferred providers, and others would benefit from the option to enroll in a PPA or in a wider range of HMOs/CMPs than had Medicare risk contracts.

But some types of employees might not consider themselves better off. Some might lose access to insurance with complete freedom of choice of provider, since some employers might abandon their basic indemnity plan, offering only PPAs and HMOs. Or the employer might have much more stringent utilization management than Medicare. Or the employer might offer a narrower range of HMOs than Medicare. This would be a particular problem for those who relocate after retiring.

It may not pose major problems to allow individual beneficiaries to elect to remain outside of the capitation agreement. They may be a small enough minority that patterns of biased selection would not have substantial effects. But what about employer benefits? Presumably, these beneficiaries could continue participation. If the employer offered only PPAs and HMOs, this would mean that Medicare benefits would be supplemented only if preferred providers were used. But such restrictions would also apply in the absence of a capitation agreement.

MANDATORY VOUCHERS

Under this option, traditional Medicare would be eliminated. The entitlement to health care coverage would continue but be transformed into a defined amount of money that could be used only to purchase a qualified health plan. A mandatory voucher would not necessarily involve the mailing of certificates to beneficiaries who would in turn redeem them at health plans (as in the food stamp program). Administrative efficiency would probably rule out most direct transactions between Medicare and its beneficiaries. Presumably, enrollment in a particular plan would continue until the beneficiary decided to switch to another plan or died.

Mandatory vouchers would differ from current law in three critical areas. First, the definition of a qualified health plan would be broadened to include fee-for-service health plans with unlimited choice of provider. Second, the amount of the Medicare entitlement would no longer be determined by the cost of services under traditional Medicare but through some other method. Third, a residual government plan for those not otherwise electing a private plan would not be offered.

The first two areas were discussed above as independent options. The discussion in the section on broadening of the definition of qualified plans indicated enthusiasm concerning the potential of capitation

payments to employer-based health plans but expressed doubt about whether freestanding fee-for-service plans with unlimited choice of providers could compete with traditional Medicare. The next section, on pricing, spells out a variety of options concerning how the linkage between the Medicare entitlement and the experience of traditional Medicare could be broken.

Either of these objectives could thus be achieved without transforming Medicare into a mandatory voucher. Thus, the merits of a mandatory voucher revolve principally around the maintenance of a fee-for-service health plan run by the federal government.

The merits of continuing a government-run health insurance plan are more complex than the issue of public versus private enterprise, however. The roles of the public and private sector would not change a great deal if traditional Medicare were abolished. In traditional Medicare, private carriers do most of the administrative work anyway, and many of the functions performed by the government now, such as eligibility determination and policy with regard to coverage and benefit structure, would continue to reside in the public sector. The latter would become part of the plan qualification process.

A more important implication of whether to have a traditional Medicare or not is that it is a residual plan—a plan that one is automatically enrolled in unless a preference is expressed for another. It guarantees coverage to those eligible for benefits.

Perhaps more important, it does not incur any marketing costs. If the residual plan were constructed well, many beneficiaries would be pleased with it, and substantial marketing costs would be avoided.

Whether Medicare meets this last test is not known, because it has not been subjected to a fair market test. The popularity of private supplemental coverage ("Medigap") may indicate that many desire less cost sharing, but the extensive subsidization of supplemental coverage, through the tax system and through lack of responsibility for induced increases in Medicare reimbursement, distorts the test. Indeed, this subsidization might get in the way of the market test that would ensue if private fee-for-service plans with unlimited choice of provider were permitted.

Aside from economizing on marketing costs, a residual fee-for-service plan would have importance because of its size. We assume that a residual plan would capture most of the market for health plans with unlimited choice, whereas without such a plan, the absence of important economies of scale would mean that a number of private plans would divide this market. Thus, only with a residual plan would the subscribers favoring fee-for-service payment and an unlimited choice of providers have any market power in dealing with providers.

Whether such market power is a good thing or not is subject to debate. One could argue against it on the grounds that monopoly is

generally not a good thing. But one could argue in favor of it as countervailing the power conferred on providers by this type of insurance. If the insured are not to have incentives to choose providers on the basis of price, they are likely to pay too much. A plan having market power may counterbalance such a tendency.

Probably overwhelming the foregoing economic discussion are the political aspects. Medicare is one of the most popular public programs, one that protects most of the elderly (and their adult children) from the financial ravages of illness and increases access to care for many. It is inconceivable that Congress would seriously consider the elimination of traditional Medicare in the foreseeable future, thus making discussion of mandatory vouchers purely "academic."

In summary, the essence of a mandatory voucher appears to be the elimination of a residual health plan. The advantages of such a step pale when compared to the disadvantages mentioned and the political furor that would result from questioning the continuation of such a longstanding popular institution. A mandatory voucher would be highly premature at this point, where only 3 percent of beneficiaries are enrolled in HMOs, and risk contracting under Medicare has yet to be evaluated. Private health plans need to pass a market test before serious consideration can be given to a reduction in the role of traditional Medicare.

V. CAPITATION POLICY OPTIONS: REFINEMENTS TO CURRENT POLICIES

This section discusses options that do not reflect a change in philosophy from Section 114 of TEFRA. They are important options to refine current policies but are also relevant to the deregulation and extension options discussed in the previous section.

MARKETING, ENROLLMENT, AND CONSUMER INFORMATION

Under current law, Medicare's role in this area is limited to policing the enrollment and marketing activities of the plans. Virtually no consumer information is provided by the program.

The goals of Medicare's supervision of enrollment and marketing are that the activities not be discriminatory and not be misleading to beneficiaries. Nondiscrimination goes beyond standard prohibitions against using age, race, or sex as a criterion for acceptance; Medicare also restricts plans from marketing only in high-income areas, for example. This is particularly important in preventing preferred risk selection—attempts to recruit only those whose expected use is lower than average. Prohibitions on discriminatory marketing are likely to be very difficult to enforce, since HCFA personnel are unlikely to be as familiar with the demographics of different local media as local HMO managers.

Plans must accept all Medicare applicants on a first-come, first-served basis up to the capacity of the plan. This provision may be somewhat easier to enforce, since those denied enrollment may complain to HCFA.

That marketing not be misleading to beneficiaries is more straightforward in concept, though not necessarily in administration. Nevertheless, previous activities by the Federal Trade Commission in this area have developed significant experience in making such judgments.

Medicare may be able to increase the number of beneficiaries enrolling in HMOs and CMPs by supporting the brokering of information to beneficiaries on health plans available to them. This assertion is based on the possibility of significant economies in informing beneficiaries through a joint medium about all of the private health plans operating

in their area. Should this prove to be the case, brokering efforts would decrease the costs to an area's health plans of gaining an additional Medicare enrollee, thus leading to a combination of lower premiums and additional enrollees informed about HMOs and CMPs. Both, in turn, would lead to more enrollees.

Because HMOs and CMPs are new concepts to the elderly, much of the information that they require before enrolling in a plan applies to all qualified health plans. Only after the concept of a health plan and the nature of the Medicare capitation benefit is understood can beneficiaries focus on which plan would be best for them. In a sense, a large part of the marketing task at present involves selling private health plans in general, with the main competition being a combination of the regular fee-for-service Medicare program and "Medigap" insurance.

Private health plans have an incentive to underinvest in the dissemination of information about Medicare's private health plan options in general, however, unless they are the sole or dominant plan in a market. They are not in a position to capture all of the increase in enrollment in private health plans that their marketing supports but must bear all of the costs. This is the classic problem of a public good. Brokering information about all of the health plans operating in an area has the potential to avoid this underproduction of information. On the other hand, these incentives apply to all advertising. Advertising for Toyotas raises the demand for cars in general. Few allege a problem of too little advertising overall.

Medicare could pursue brokering in two ways. It could communicate the information directly, much as the FEHBP does, or it could fund private organizations to do the work. Because the FEHBP approach could be contracted to the private sector, the difference between the two approaches may be one of centralization versus decentralization, rather than whether the public or private sector is to disseminate the information.

Under the FEHBP approach, the government (or its contractor) would develop a standard format for the presentation of information about qualified private plans and then obtain the particular facts from the plans. The resulting publication describing all of the qualified plans in an area would then be sent to all of the beneficiaries. Interested beneficiaries would then contact the plans directly for further details. Beneficiaries electing to enroll could do so either through HCFA's marketing contractor or through the plan itself. This alternative channel for enrollment may reduce biased selection by making it easier for those with mobility restrictions to enroll.

The alternative approach would subsidize a local organization in each market area to perform this function. HCFA currently has

demonstration projects under way that provide grants to local consumer organizations to convey information to Medicare beneficiaries on private health plan options. An important advantage of this approach, at least during the early years of such efforts, is the opportunity for extensive experimentation in dissemination methods. We certainly do not know which methods are most cost effective now, and experimentation is desirable. Funding a different group in each metropolitan area would foster such experimentation. Funding an additional organization to serve as a clearinghouse and evaluator might expedite the learning process.

HCFA would have to play a strong role in development of even a decentralized brokering function. It would have to award contracts to perform the function on the basis of competitive bidding, under which creativity of the method proposed was given prominence, along with price, as a criterion for selection. HCFA would have to avoid the temptation to decide which approach was best and to select only contractors proposing that particular method. On the other hand, such a competition would be similar to awarding research contracts, an area where HCFA has ample experience. HCFA would then attempt to evaluate the cost effectiveness of the alternative methods used in different areas.

Once the superiority of certain approaches became established, a national approach might be pursued, primarily because of lower costs. At this point, economies of scale in such a function would be likely. By awarding fewer brokering contracts for larger areas, the contracting process would be far less an administrative burden to HCFA.

At this point, the costs of such a brokerage program are very uncertain. Aggregate costs would be highest initially, when the focus of marketing efforts would be on private health plans in general. Once the focus evolves more to competition among private health plans than between the plans and traditional Medicare, the brokering activity could be phased down.

A brokerage program need not increase Medicare outlays. Such joint marketing would to a large extent be a substitute for efforts by individual plans, so that it would be appropriate for Medicare to charge the plans for such activity through reduction of their Medicare capitation payments. In calculating the AAPCC, the costs of the brokering program could be recognized as part of the payment from Medicare, so that when they were added to the direct component of capitation payments, the plans would receive in total 95 percent of the costs to Medicare of fee-for-service enrollees.

QUALITY ASSURANCE

Section 1876 has many provisions intended to protect the quality of care, as do the implementing regulations. HMOs/CMPs are also subject to state licensing standards and other standards applied to all Medicare providers—for example, HMOs/CMPs must provide services through providers and suppliers that meet applicable statutory definitions and regulations. HMO/CMP enrollees, like all Medicare beneficiaries, also have access to Medicare's appeals process.

These requirements grant HCFA (and state agencies) considerable authority to discipline poor organizations or to prevent them from gaining entry to the Medicare program. Many critics of a private health option have nevertheless expressed concern about the quality of care under such a program. Perhaps more significantly, many *proponents* of the idea have expressed similar concerns. Proponents of the private health plan option fear that political support for the PHPO concept could be undermined by even a few isolated instances of poor care.

This section will address the following questions:

- Do ADSs provide high-quality care?
- Should additional quality-related requirements be imposed on HMOs/CMPs?
- Should medical judgments made by HMOs/CMPs be subjected to the Medicare appeals process and PRO review?

These questions cannot be answered definitively without more empirical evidence and better measures of quality than we now have. The purpose of this section is to present a conceptual framework for discussing quality assurance in HMOs and CMPs.

The following conceptual analysis cannot *prove* that HMOs and CMPs provide as high a quality of care as fee for service. Even if more empirical evidence were available, it would be difficult to generalize about all HMOs and CMPs; some will provide high-quality services and some will not, just as in the fee-for-service sector. Conceptual analysis may be useful, however, in evaluating who ought to bear the burden of proof on HMO and CMP quality. Specifically, it may help us answer the question: Do HMOs and CMPs require special vigilance because of their organization, financial incentives, and their apparent success in reducing the cost of care?

Do ADSs Provide High-Quality Care?

Suspicion about ADSs, where it exists, seems rooted in their financial incentives to reduce services; the implicit assumption seems to be that more health care is better. This assumption is dubious, at least if one assumes that "quality" is best measured by monitoring differences in health status. Section II reviewed some of the research on this issue.

Of course, these and other similar studies do not prove that use can be cut without forgoing any benefits. Even if one stipulates that use can be cut without any measurable effect on *health status*, that is not to say that additional care provides no benefit. A given hospital admission, for example, may shorten the duration of a person's illness or ease discomfort without altering the person's long-term health status. Whether the care is "appropriate" or "needed" is often more subjective than objective.

Patients have different attitudes toward risk and different levels of tolerance to discomfort and different values (and opportunities) regarding dependence on families and friends. All of these factors, and others, must be considered in determining appropriate medical practice in any given case. For many conditions, in short, there is no one "right way" to practice medicine.

Although the available evidence does not identify quality differences between HMOs and fee-for-service Medicare (see Sec. II), much of the literature applies to large prepaid group practices. IPAs, especially the newer models, may have different results.

Like traditional insurers (including Medicare), IPAs have difficulty establishing strong incentives for efficiency for individual providers, especially physicians. As a result, many IPAs rely heavily on fee-for-service payment, and where they use other approaches (e.g., capitation of primary care physicians), the amount of financial risk borne by the physician is often capped at a low level.

Developing a risk-payment system for physicians is complicated by their relatively small volume of patients (compared to hospitals) and by their relatively high degree of specialization. Because risk-payment systems depend heavily on averaging—i.e., that any given provider will treat a mix of high- and low-cost patients—low volume and specialization can be serious problems.

The alternative used by many IPAs is "group incentives"—e.g., withholding a portion of each physician's fees until actual year-end costs can be compared to projected costs. But withholding systems confront a "free-rider" problem: Because any given physician's decisions have only a small effect on his or her compensation at the end of the year, the incentives for changing behavior may be quite weak.

To cope with these problems, IPAs often depend heavily on administrative controls on utilization (e.g., requiring prior authorization of nonemergency treatment) and on physician education. Some physicians who organize and manage IPA-type plans believe that education—sometimes called "changing the physician culture"—is the key to long-term success. Administrative controls that override physician decisions may be deeply resented unless the physician can be persuaded that the new standard of practice is medically appropriate, as well as less costly.

Some physicians are suspicious of HMOs/CMPs because they fear that lay managers, not physicians, will determine the standard of care. Physicians, these HMO critics contend, must preserve their complete independence from payers to perform their fiduciary responsibilities to their patients. A third party's ability to influence a physician is a function of its market power as well as its organizational structure. So long as an HMO does not dominate the market, physicians may refuse to deal with impunity—a liberty they may not have in dealing with Medicare, given its substantial market power. If a physician does not exercise the opportunity to resign from a poor-quality HMO, the problem may not be the HMO concept but the physician's judgment. Questionable physician judgment poses serious problems in any context, including fee-for-service Medicare.

HMOs and CMPs can also help assure quality by serving as the consumer's agent in screening physicians. In exchange for the consumer's giving up his or her free choice of provider, the HMO or CMP assumes responsibility for screening providers. Given the complexity of such choices, many consumers will find the exchange appealing—particularly consumers who do not have a well-developed relationship with a primary care physician who can serve as an expert adviser.

Unlike the members of a hospital medical staff, who may perform a similar screening function in the fee-for-service sector, the HMO or CMP has a direct financial stake in the selection. Poor selections could easily damage the organization's reputation and its financial prospects. Since the physicians participating on a hospital's medical staff usually are not economic partners, their incentive to screen carefully may be somewhat weaker.

HMO/CMP advocates, as well as critics, are prone to unsupported claims about quality. Some proponents have argued, for example, that HMOs are better than fee-for-service providers at maintaining health—that is, disease prevention. The evidence for that contention is ambiguous, at best. According to Luft (1980), if one corrects for differences in the scope of benefits—traditional insurers usually

provide less comprehensive coverage—HMO enrollees do not appear to receive more preventive services.[1] Even where HMOs do provide more preventive services, it does not seem to explain their lower hospitalization rates and costs. The effectiveness of many preventive services is in doubt, and many new HMOs have low hospitalization rates right from the outset, long before any preventive services could have had an effect.

The economic incentives facing HMOs/CMPs may, however, put a premium on remedying problems as efficiently as possible, once diagnosed. Unlike fee-for-service providers, HMOs benefit financially if a patient gets well quickly, not slowly. Since they are at risk for *total* health care costs, not just a portion, HMOs do not have an incentive to "ping-pong" patients from one provider to another. The same cannot be said of fee-for-service providers. Though most fee-for-service providers try to resolve problems as quickly as possible, they are not rewarded financially for doing so, at least not in the short run. (In the long run, an efficient practice style might attract more patients.) The efforts of fee-for-service providers are testimony to their professionalism and humanitarianism, not to a superior payment and delivery system.

The perverse incentives plaguing the fee-for-service Medicare program may worsen as the program introduces piecemeal incentives for efficiency. Medicare's prospective-payment system, for example, encourages early discharge of hospital patients, even if the result is a significant increase in the likelihood of a second admission or other complications. To combat this problem, PROs review all readmissions occurring within 15 days of a prior admission. Only time will tell how effective PRO monitoring will be.

A recent study by Lewin and Associates (1986) provides anecdotal support for the hypothesis that HMOs treat patients differently because of their concern for long-term costs. As part of a study of subacute/transitional care in Minnesota hospitals, Lewin and Associates studied the care offered by four HMOs with Medicare enrollees. They found that HMOs sometimes considered it

> unreasonable and undesirable to restrict inpatient hospital care only to those meeting strictly-applied criteria for "medically necessary" acute care. . . . [One HMO] reported that in its experience, the overall outcome of care was sometimes better when patients stayed in an acute setting somewhat longer before moving to a lower level of care. (pp. 2.11–2.13)

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[1]The RAND Health Insurance Experiment found, however, that those enrolled in Group Health Cooperative of Puget Sound received more preventive services than those assigned to fee-for-service insurance (Manning et al., 1984).

DRG 209 (hip replacement) was cited as a type of case where this is often true. Hospitals, in contrast, are applying acute care criteria quite stringently because of the incentives inherent in PPS. Although a growing number of hospitals are providing subacute patients with "transitional" care, it is generally not a covered service under the traditional Medicare program; the beneficiary must therefore pay the cost out-of-pocket.

For better or worse, practice patterns in ADSs and under traditional Medicare may converge in the long run. Narrowing of the differences will be the inevitable byproduct of the rapid growth in HMO/CMP enrollment and in the number of participating providers. To continue growing, HMOs/CMPs must add patients and providers who did not join sooner precisely because they were concerned about quality. Furthermore, HMO/CMP efforts to educate providers will have spillover effects on fee-for-service practice to the extent that some providers participate in both types of financing arrangements.

Disenrollment and the Quality of Care

Newhouse (1982) observes that HMOs/CMPs can reduce their costs per capita in three ways: reducing the costs of providing any given level of services (production efficiency), reducing the services provided for *any given condition*, or avoiding patients who need services (skimming). The last, of course, does not reduce costs but shifts them to other payers. In a vigorously competitive market, this strategy may appeal to some competitors. Once some plans adopt it, others may follow suit in "self defense."

The biased selection problem is discussed in detail in Sec. V, so we will not dwell on it here. One dimension, however, bears mention in a discussion of quality assurance.

A refined payment formula, for example, one that includes an adjustment for prior use, may reduce the incentive to avoid *enrolling* patients who previously required a lot of health services. It would not, however, reduce the incentive to encourage *disenrollment* by high-cost patients. A payment formula adjusting for *prior* use could even increase the financial rewards from such behavior. A plan could enroll a patient with a high rate of prior use (and a high AAPCC) in the hope that his or her *future* use will be lower. If that proves not to be the case, the plan could, at least in theory, encourage the patient to disenroll. As Newhouse observes, the plan could use a variety of subtle, and not-so-subtle, techniques, including denying access to needed care and simple rudeness.

This incentive for "dumping" is not unique to the PHPO strategy. It is inherent in any payment formula providing an incentive to reduce the volume of services—that is, any formula that "bundles" services

together for purposes of payment. One way to reduce, but not eliminate, the problem is to force the initial provider to bear at least some portion of the patient's costs even after he or she has left the provider's care (see the additional discussion in Sec. VI).

There is as yet little evidence of extensive dumping by HMOs/CMPs participating in Medicare. The disenrollment rates of plans with Medicare contracts have generally been low. As of April, 1986, the total disenrollment rate for HMOs and CMPs was about 2.5 percent per month (176,348 disenrollees out of 7,125,194 enrollee-months).[2]

Medicare beneficiaries disenrolling from HMOs and CMPs were not necessarily unhappy with the care they received. The 2.5 percent per month rate includes beneficiaries who disenrolled because they moved out of the HMO/CMP's service area. Others were attracted into another private plan. About 60 percent of the disenrollees elected to enroll in another HMO or CMP, the remainder returning to traditional Medicare.

Even if the Medicare disenrollment rate were lower, it would not disprove the hypothesis that HMOs will seek to disenroll high-cost patients. To obtain important financial benefits, an unethical HMO need not "dump" large numbers of Medicare patients, only those patients with the highest expected costs. The distribution of health care expenses is quite skewed, with small numbers of patients accounting for a high percentage of total outlays. HCFA should consider monitoring the subsequent expenditures of HMO disenrollees to determine whether they use an unusually high amount of services.

Noneconomic considerations, for example, professional ethics, may curb inclination to "dump" high-cost patients. Plans must also take into account the long-term economic implications of large-scale dumping. Once a plan develops a reputation for such practices, it may find the label difficult to shed, with detrimental effects on its ability to attract qualified physicians and patients. HCFA could facilitate this process by publishing disenrollment rates for the HMOs and CMPs participating in Medicare, much as consumer guides publish data on auto insurance companies cancelling policies.

Should More Quality-Related Requirements Be Imposed on HMOs/CMPs?

At this early point in the HMO/CMP program, it is difficult to assess the effectiveness of the quality standards imposed under Section 1876 and the implementing regulations. Many new requirements have

[2]Gary Bailey, Office of Prepaid Operations, HCFA, personal communication, May 1986.

been imposed, supplementing the standards imposed by states, the tort system, and the requirements imposed on all Medicare providers (for example, the conditions of participation for institutional providers).

Following are *some* of the quality-related requirements imposed on HMOs and CMPs under Section 1876 and the implementing regulations:

- HMOs/CMPs must be organized under state law and meet any attendant state requirements, including licensing standards. [417.407(a)]
- HMOs/CMPs must provide services through providers and suppliers who meet applicable Medicare definitions and regulations. [417.416(a) and (b)]
- HMOs/CMPs must provide all Medicare-covered services and patient cost sharing may not exceed the actuarial equivalent of what beneficiaries would have paid had they remained in the traditional Medicare program. [417.425(a)(3)]
- HMOs/CMPs must demonstrate adequate operating experience and meet minimum enrollment requirements (5000 enrollees for urban organizations and 1500 for rural organizations). [417.410(e)(2)]
- Medicare and Medicaid beneficiaries may constitute no more than 50 percent of the organization's total enrollment. [417.413(d)]
- HMOs/CMPs must have a quality assurance program and grievance procedures. [417.418 and 417.436]
- If dissatisfied with the HMO/CMP's ruling, Medicare beneficiaries may appeal certain decisions through the Medicare appeals system. [417.600]
- HMOs/CMPs must make services available and accessible (24 hours a day and seven days a week when medically necessary) and assure continuity of service. [417.416]
- HMOs/CMPs must reimburse enrollees for service provided other than through the organization if the services were medically necessary and immediately required, and it was not possible to obtain them through the organization. [417.414(c)]
- Medicare beneficiaries may disenroll from HMOs and CMPs on short notice.
- HCFA may impose a $10,000 penalty on HMOs for not providing needed care (Omnibus Budget Reconciliation Act of 1986).

In addition, recent legislation (the Consolidated Omnibus Reconciliation Act of 1985 and the Omnibus Budget Reconciliation Act of 1986)

requires review of HMOs/CMPs by PROs or other QROs. Some proponents of the ACR rule contend that it too will help protect quality by limiting the potential for HMOs/CMPs to earn large profits through arbitrary cuts in service (a topic discussed above).

To be effective, some of the foregoing requirements require continuous monitoring. The existence of a quality assurance program, for example, does not assure quality. If this requirement is to be meaningful, HCFA must examine how the program works in fact, not how it appears on paper.

Many of the standards are also subjective; determining whether an organization meets a standard therefore requires HCFA to exercise judgment—and run a corresponding political and legal risk. Subjective judgments are more likely to be challenged in the courts and through the political process.

Monitoring and enforcing objective standards would almost certainly prove easier. HCFA may therefore wish to consider increasing some of the objective requirements to minimize the dependence on subjective ones. Increasing the minimum enrollment requirement, for example, may be a relatively simple way to weed out some (but certainly not all) poor quality plans. At a minimum, a higher enrollment threshold would make HCFA's job easier. Fewer plans would have to be examined, and larger numbers of enrollees would make analyses of quality easier. Any high-quality plans failing to meet the enrollment standard will eventually qualify. Increasing the minimum enrollment threshold, which would require legislation, would also reduce the risk that flaws in the AAPCC and ACR will drive plans into bankruptcy.

Similarly, a case can be made for requiring HMOs and CMPs to draw an even higher proportion of their members from the private sector than the current 50 percent. Most private enrollees purchase their coverage through employment groups. Employers and unions often screen health plans for quality. They can respond much more readily than Medicare to complaints from enrollees concerning underservice. Indeed, employers have begun to increase their efforts to monitor quality. The presence of many private enrollees may therefore become a market-based quality control.

The problem with an enrollment proportion requirement is the potential burden to plans in retirement areas and its precluding plans specializing in geriatric medicine. But market-based quality control may be so much more effective than administrative measures that the enrollment restrictions could be a reasonable price to pay. Although anecdotal, it is noteworthy that the one HMO with a Medicare risk contract in which quality of care has become a public issue has had a waiver from the enrollment ceiling permitting up to 75 percent of enrollees to be Medicare.

Should Medical Judgments Made by HMOs/CMPs Be Subjected to Case-by-Case Review by Administrative Law Judges and PROs?

Perhaps the most troublesome of the quality controls built into Section 1876 is the provision subjecting HMO/CMP decisions to the Medicare appeals process. Case-by-case review of HMO/CMP decisions may conflict with one of the primary goals of the PHPO strategy: decentralization of subjective and uncertain medical decisions. Because a similar threat exists in subjecting HMO/CMP decisions to review by PROs, we will discuss the appeals process and PRO review together.

As discussed in Sec. II, the rationale for the PHPO strategy is founded on the subjective and personal nature of many medical decisions. Because of the subjectivity and uncertainty surrounding medical practice, the argument goes, health care providers and their patients should be granted maximum flexibility to determine the appropriate course of treatment, subject to a ceiling on the government's contribution (i.e., the capitation amount).

Except in the unusual cases where there is a clear consensus about appropriate medical treatment, external review mechanisms may be ill-equipped to decide appropriate medical practice. Outside review would be most likely to produce sound decisions if there were a scientifically derived standard of medical practice for any given set of symptoms. Then standard rules could be developed and administered by laymen or by physicians with no firsthand knowledge of the patient. According to Wennberg (1984), however, it is simply not true that "most medical services are undifferentiated necessities, dispensed according to scientific norms." Clear-cut cases may be the exception, not the rule.

The inherent ambiguity surrounding medical practice is especially evident in treating elderly patients. According to Wennberg (1984), "[t]he [medical] procedures exhibiting the most variation are often for conditions that are part of the aging process. . . . Examples include hysterectomy for noncancerous conditions, prostatectomy for benign hyperplasia of the prostate, . . . and coronary bypass for mild angina. Well-defined scientific norms simply do not exist to limit the practice options physicians select to treat these maladies."

In theory, PROs and administrative law judges could be instructed not to interfere with HMO/CMP judgments except where a clear, scientifically based norm has been violated. Experience with the tort (malpractice) system suggests, however, that such limits on the scope of review may not be easily enforced. Determining when there is "a clear, scientifically derived norm" may itself prove difficult, let alone applying the norm to individual cases.

An example may help illustrate the threat to HMO/CMP medical prerogatives. HCFA is in the process of adding heart transplants to the list of Medicare-covered services. Certain restrictions on that coverage are being considered for both cost and quality reasons, and the rationale for any given restriction may be a blend of cost and quality considerations. For example, coverage may be limited to transplants performed at certain institutions doing a minimum number of transplants per year. If experience with other complicated procedures is any guide, those "high-volume" institutions will probably have lower costs per case and higher success rates than hospitals that do few heart transplants.

Assuming that HCFA does decide to cover transplants only at select institutions, how will the transplant rule be applied to HMOs/CMPs? What if an HMO wants to perform a transplant at an otherwise well-qualified facility that falls just short of HCFA's minimum volume threshold? Given that the HMO is at risk for any increase in expenses resulting from low volume, shouldn't the HMO's physicians be free to exercise their own medical judgment? What if an HMO decides that a given patient is not a good candidate for a heart transplant because he or she lacks adequate family support and has some complicating medical conditions? Will an administrative law judge or PRO be free to second-guess the HMO's medical judgment?

Of course, fee-for-service physicians may be subject to some of the same second-guessing. The problem is that some of the HCFA transplant standards will be based on *both* cost and quality considerations. The former should be irrelevant for HMOs and CMPs, but it may not be feasible to separate cost and quality considerations.

CAPITATION FOR PART B SERVICES ONLY

Medicare could allow private health plans to accept a capitation payment for Part B services only (principally physicians' services), or for physicians' services only, with the beneficiary continuing under traditional Medicare for the remainder of covered services. The advantage of this option would be an expansion of the range of private organizations willing and able to offer services on a capitated basis. Disadvantages include the fact that the excluded services have been those where HMOs have traditionally had the greatest success in containing costs, incentives to substitute inpatient for outpatient services, and a potential problem of increased budget outlays resembling that faced when HMOs serving Medicare beneficiaries on a cost basis converted to a risk basis.

The Concept

Part B capitation would work in much the same way as current capitation for the full range of Medicare covered services does. Qualified plans would agree to provide Part B services through their employees or physicians with which they contract. The plans would not be at risk for Part A services. Plans would be paid a capitation rate equal to 95 percent of the Part B component of the AAPCC.

Private plans would succeed under capitation if they provided fewer Part B services than fee-for-service Medicare or obtained the services at a lower price. The potential for using physician incentives to reduce the volume of Part B services is perhaps the more important.

Advantages

The major advantage of the option is the potential for attracting additional organizations to serve the Medicare population on a capitated basis. Large multispecialty group practices that operate on a fee-for-service basis, for example, might find Part B capitation attractive because it is much less risky to them than risk contracts under current law. If enrollees used more services than projected, it need not result in significant monetary losses. Physicians could deal with the shortfall by working longer hours. This would be analogous to salaried employees working longer hours during a peak period—their earnings per hour would fall but cash flow would not be affected. In contrast, full capitation would make the group responsible for the three-quarters of Medicare outlays that go to entities other than physicians.

Disadvantages

The disadvantage that is most readily apparent is that Part B services account for only 32 percent of Medicare outlays. Thus a 20 percent reduction compared with the fee-for-service experience would save only 6 percent. If Medicare paid 95 percent of the AAPCC, the reduction in Medicare outlays would be only 2 percent. If some of the Part B only plans would otherwise have accepted capitation risk for all Medicare services, the benefits from capitation could be reduced. On the other hand, Part A outlays could be reduced in conjunction with incentives to reduce physician services, for example less use of surgery.

Further, HMOs have had their greatest success in reducing rates of hospital use. The RAND study of Group Health Cooperative of Puget Sound showed a 40 percent reduction in the rate of hospital admissions compared to free care in the fee-for-service plan but a similar rate of

use of physicians' services (Manning et al., 1984). The nonexperimental literature on HMOs also indicates that most or all of the cost reduction is obtained from lower rates of use of hospital services (Luft, 1981). With this experience by HMOs, a private health plan at risk only for Part B services would have to be highly innovative to achieve significant savings.

This need for innovation would be exacerbated by health plans having to deal with the need in many cases to pay physicians higher fees than they receive from Medicare. In 1984, 84 percent of physician claims to Medicare were reduced—by an average of 24 percent. Many physicians collected the additional amount from patients. Thus a plan would have to pay physicians less than what they get under regular fee-for-service payment just to avoid paying more than Medicare does.

The incentives facing a health plan at risk only for Part B services raise serious concerns. Since Part A services would continue to be reimbursed under fee for service, plans would have incentives to substitute those services for Part B services. The substitution of inpatient services for hospital outpatient department and surgicenter services would be an example. Not only would such a substitution increase the overall cost of medical care, but it would increase Medicare outlays directly. Medicare would in a sense be paying twice for such services—as part of the capitation rate and then through regular fee-for-service payment under Part A.

A number of options might be considered to deal with the incentive problem. Capitation could be limited to physicians' services. This would exclude laboratory services, outpatient surgical facility charges, and X-ray charges. If only physician charges were at risk, incentives to hospitalize would be removed for the most part. Drawing a boundary around the services to be capitated that is narrower than Part B might add to administrative problems, however. Having the plan also accept partial risk for hospitalization—perhaps 25 percent—would be additional insurance against perverse incentives but would not be adequate if the entire range of Part B services were capitated.

Part B capitation might pose an additional budget risk to Medicare beyond that of biased selection in enrollment. Although the research literature is not extensive, some studies have found rates of use of services in some large multispecialty group practices that operate on a fee-for-service basis to be comparable to those in prepaid group practices (Scitovsky, 1981; McClure, 1984). Should such low-cost groups convert the Medicare patients that they treat from fee-for-service payment to capitation payment, Medicare would pay more for those services. On the other hand, HMO/fee-for-service comparisons are dominated by differences in hospital use, whereas the relevant comparison

here is Part B services. Future research may indicate whether this is a serious problem.

When Section 114 of TEFRA was enacted, special provisions were added to protect the trust funds against additional outlays associated with prepaid group practices enrolling under risk contracts Medicare beneficiaries that they were already serving on a fee-for-service basis. Assuming that Medicare was paying less for services to those beneficiaries as a result of lower rates of utilization in HMOs, limits were placed on the number of beneficiaries that could be converted to risk contracts.

The same phenomenon might be encountered if fee-for-service group practices undertake risk contracts and enroll beneficiaries that they already serve on a fee-for-service basis. This would occur whether the capitation payment was for Part B only or all services. However, depending on the extent to which a Part B only option draws in fee-for-service group practices that would not otherwise have participated in risk contracting, the problem could be a larger one. Without prior enrollment, however, adjustments similar to the conversion limitations in TEFRA would be very difficult.

In conclusion, capitating Part B services only appears to have limited potential and some concrete disadvantages. The concept is not an attractive one to seek legislative authority for at this point. A demonstration might be warranted, but it would not have the highest priority for limited funds.

MEDICARE-MEDICAID INTERACTION

Data from the Survey on Income and Program Participation indicate that 8 percent of noninstitutionalized Medicare beneficiaries are also eligible for Medicaid. Often dually eligibles are discouraged from enrollment where there is a premium because the plan does not have a contract with the state to cover the premium. A Medicaid recipient's eligibility for Medicare may constrain Medicaid programs' efforts to increase the use of capitation.

When a Medicare beneficiary enrolls in an HMO or a CMP, Medicare reimburses the plan on a capitated basis, just as for a beneficiary not dually eligible. Indeed, the capitation rate is different, since Medicaid eligibility is one of the factors used in the AAPCC. Medicaid programs may then pay for the cost sharing in the form of a premium to the HMO.

Perhaps the major problem with current policy concerning the dually eligible is that the incentives to enroll in private health plans

are limited. The dually eligible do not face the out-of-pocket costs of "balance billing," since physicians are prohibited from charging Medicaid patients more than the amount allowed by Medicare. Access to physician services is not the problem for the dually eligible that it is for other Medicaid recipients because Medicare physician payments are much higher than those in many Medicaid programs. If an HMO has low costs and passes the savings on to enrollees through not charging a premium to cover the deductible and coinsurance, the dually eligible beneficiary does not gain, since Medicaid was paying these expenses in any case.

Some states have been experimenting with numerous ways of increasing the use of alternative delivery systems in Medicaid. Some have obtained waivers of Medicaid freedom of choice provisions to enroll substantial numbers in HMOs or other types of arrangements. Medicaid programs cannot limit a Medicare beneficiary's freedom of choice of provider, however. Thus, special provisions must be devised when dually eligible persons are included in programs to enroll substantial numbers of recipients in HMOs.

In a Minnesota demonstration, the Medicaid program limited its coverage of the Medicare coinsurance and deductible to a premium paid to HMOs. But Medicare could not require dually eligible beneficiaries to enroll in HMOs. Instead, Medicare is paying the HMOs on a cost basis (as if they were fee-for-service providers). Incentives to confine the use of services to the HMO are strong, since the beneficiary is not entitled to Medicaid payment of coinsurance and deductibles when services are used outside the HMO. HMO efficiencies will be realized by Medicare and Medicaid as long as HMO physicians follow the same practice pattern as they do for the rest of HMO patients—a seemingly likely occurrence.

Although this aspect of Medicare-Medicaid interaction is awkward, we do not recommend a change in the law. The principle of freedom of choice of provider for Medicare beneficiaries is important, and proposals to change it are likely to engender suspicion. It does not pose a significant enough obstacle to the use of capitation to consider such changes.

VI. SETTING CAPITATION PAYMENT RATES

Setting the price that Medicare pays an HMO or CMP involves two distinct aspects—the computation of an aggregate rate and adjustments to reflect the relative costs of serving the population that enrolls in each plan. Under current policies, the aggregate rate is 95 percent of the U.S. per capita cost (USPCC). It is then adjusted to reflect the characteristics of the population served by the health plan by calculating an AAPCC for each class of Medicare enrollees.

In the short run, methods to adjust payment rates to reflect the characteristics of enrollees should be refined. Otherwise, substantial windfalls—both positive and negative—will affect the health plans and their enrollees. In the long run, when a higher proportion of Medicare beneficiaries is enrolled in HMOs, the aggregate rate should no longer be based on the experience of the non-HMO population.

This section begins with a description of how the AAPCC is calculated. It then proceeds to a discussion of options to modify the adjustments to reflect the characteristics of a health plan's Medicare enrollees and the method by which the aggregate rate is set.

THE AAPCC

In defining the AAPCC, it is difficult to improve on the language accompanying the final rule:

> The AAPCC is an estimate of the average per capita cost that would have been incurred by Medicare on behalf of each class of Medicare enrollee of the organization if that class of enrollee had received its covered services from providers and suppliers other than the eligible organization in the same or similar geographic area served by the organization.[1]

What makes the AAPCC such a difficult concept is its hypothetical nature. It seeks to approximate the costs that would have been incurred if the enrollee had remained in the fee-for-service system. Many ways exist to make these approximations, some more accurate than others.

Calculation of the AAPCC begins with a projection by the Medicare Actuary of the national average Medicare per capita cost for a calendar

[1] *Federal Register*, January 10, 1985, p. 1318.

year. Separate projections are prepared by enrollment status (aged versus disabled) and for Part A and Part B. The projection includes a loading for those Medicare administrative costs incurred by intermediaries and carriers.

Then geographic adjustments are determined by county of residence. Each county's per capita non-HMO costs over a five-year period are standardized for demographic mix and then compared to the national average to obtain the county adjustment factor. To calculate the payments made to any given HMO, the county cost projection is adjusted to reflect the characteristics of the HMO's actual enrollees in comparison to those of the fee-for-service population in the HMO's service area. The following demographic factors are recognized for adjustment: age, sex, welfare status, and institutional status. The specific adjustment factors are developed from tabulations of the Current Medicare Survey for 1974–1976.

VARYING THE PAYMENT BY BENEFICIARY

The concept behind the AAPCC is to have Medicare payments approximate as closely as possible the claims that would have been paid for a plan's enrolled population had those persons instead obtained Medicare services in the fee-for-service sector. In theory, relative payments reflecting hypothetical fee-for-service claims should be highly correlated with the relative costs of caring for different beneficiaries enrolled in an HMO/CMP. The current AAPCC does not reflect either concept well, however.

The Problem of Biased Selection

Crucial to the success of the private health plan option strategy is that the AAPCC be an accurate projection of how much would have been spent on the beneficiaries that enroll in a particular plan had they remained in the fee-for-service sector. There is reason to fear, however, that the AAPCC is not a good projection of *any individual* plan's costs, even though it is an accurate predictor of *aggregate expenditures.* The individuals electing to enroll in an HMO may differ *systematically* from those electing to remain in fee-for-service Medicare. This phenomenon is known as "biased selection."

In the analysis that follows, we focus on differences in the expected costs of care of enrollees that are not captured by the pricing mechanism used. Thus, if a plan attracted younger-than-average enrollees who otherwise were typical of their age cohort, we would not label it as

biased selection. If after adjusting for age, sex, and other factors, HMO enrollees were healthier (and thereby likely to use fewer services) than their nonenrolled cohorts, we would regard that as biased selection, unless a health status adjustment to the pricing mechanism effectively reflected that difference.

If biased selection were substantial, the following could occur:

- If those who enroll in private plans would have used fewer services than their cohorts remaining in traditional Medicare, federal outlays would be higher than intended. Indeed, the private health plan strategy could increase rather than reduce Medicare outlays if biased selection were large enough that its fiscal effect outweighed the projected 5 percent margin (from paying a rate of 95 percent of the AAPCC) planned under current law.
- If those enrolling in private plans would have had higher than average use, plans might lose money on risk contracting and not continue in the program. Although this type of biased selection may raise the ACR if it is based on plan-specific data, Medicare will not pay plans more than 95 percent of the AAPCC.
- If health plans found the pattern of biased selection working both ways and unpredictable, this too might discourage participation in the program. Because Medicare pays the lesser of the ACR and the AAPCC, plans would face a risk of large losses through an unfavorable selection of risks but only limited profits through either favorable selection of risks or effective management of costs.
- If biased selection had a greater impact on health plans' profits than did efficiencies in the delivery of health care, the attention of top management would be diverted into achieving a more favorable selection of enrollees.
- If health plans were able to avoid marketing to high-risk beneficiaries, such individuals would have limited opportunities to use alternative delivery systems.

Evidence of Biased Selection

Despite the critical role that biased selection might play in a health system where competition is based on enrollment in health plans, little research is available to guide federal policymakers in assessing its magnitude in Medicare. The research evidence that is available indicates that the potential for biased selection under the current method of pricing may be a serious problem.

The research literature on HMOs, which is based on the experience of enrollment through choices offered by employment-based health plans, indicates that biased selection is important, at least when new options are offered, but the pattern is quite complex and mixed (Luft, 1981). In general, the option with the more comprehensive benefits—usually the HMO—will attract the higher users. But when a change in physician is required, those without an established relationship with a physician, who tend to be low users, are more likely to make the change to an HMO. This is likely to be an important factor with staff model HMOs but somewhat less so with IPAs, where more of those enrolling are able to continue with their existing source of care. A recent suggestion is that the basic structure of staff model HMOs—limited choice of specialists, queuing, etc.—may discourage those with chronic illness more so than others.[2]

A recent study of employees in the Minneapolis-St. Paul area offered HMOs *for the first time* showed that those enrolling had claims in the prior year 53 percent lower than those continuing their Blue Cross-Blue Shield coverage (Jackson-Beeck and Kleinman, 1983). After standardizing for age, the difference is 44 percent. Another study of the Twin Cities area (Dowd and Feldman, 1985), which examined the experience of many large employers offering a choice of health plans, found that HMO enrollees were younger and were less likely to have chronic conditions. These differences were found in those who had been enrolled in HMOs for many years as well as for those recently enrolled.

The most important evidence for Medicare beneficiaries is from a demonstration project begun in the late 1970s in which Medicare contracted with four HMOs on a risk basis (usually referred to as the "Medicare Capitation Demonstrations"). An analysis indicated that those choosing to enroll in three of the HMOs had lower rates of use during the years before enrollment than their cohorts who chose not to enroll (Eggers and Prihoda, 1982). The one HMO that did not experience this phenomenon of favorable selection was distinct in that beneficiaries for the most part did not have to change providers to enroll. This led the researchers to speculate that a reluctance to change physicians on the part of high users was responsible for the pattern. An alternative hypothesis is that those enrolling were more likely to have had unmet needs in the fee-for-service system.

If the first hypothesis were correct, it would imply that new enrollees in those HMOs that restrict choice of provider will tend to be lower-than-average users. Over time, however, as this cohort of

[2]J. Lubitz, Office of Research, HCFA, personal communication, April 1986.

beneficiaries continues to be served by the HMO, their patterns of use will move toward the average, though not necessarily reach it. As the proportion of HMO enrollment that constitutes longstanding members increases, the magnitude of biased selection would be expected to diminish.

If the second hypothesis were correct, Medicare outlays would continue to be higher over time, but the additional outlays would go to redressing problems of access and would not be a windfall to the health plan or its enrollees.

HCFA researchers have followed this group of enrollees and are analyzing their utilization experience during the demonstration period. Preliminary results for two of the demonstration sites indicate a persistence of utilization differences between enrollees and nonenrollees (Kasper and McCombs, 1985). The fact that the utilization differences after enrollment were similar to those before enrollment may give some support to the notion of prior unmet needs. If enrollees did not have greater unmet needs than nonenrollees, HMO practice patterns would have been expected to widen the differences in use between the two groups. On the other hand, if the enrollees were relatively healthy, there may have been few opportunities for capitation to reduce their use of services.

Ongoing research projects will significantly augment our knowledge of selection patterns in enrollment in HMOs by Medicare beneficiaries over the next few years. HCFA began a very large-scale demonstration of risk contracting in 1982, shortly before the enactment of TEFRA. (This series of demonstrations is frequently referred to as the "Medicare Competition Demonstrations.") Over 25 HMOs participated (with implementation of TEFRA, their contracts with HCFA were converted to standard ones without time limits), and a major evaluation contract has been awarded. Since the risk contracts in this demonstration do not differ in a substantial way from those contracts used under current law, the results should be highly relevant.

Some early results from the Medicare Competition Demonstrations indicate that healthier-than-average beneficiaries enrolled in these HMOs as well. The General Accounting Office (GAO) has studied mortality rates of those who enrolled in some HMOs under the demonstration (GAO, 1986). HMO enrollees had lower mortality rates than their fee-for-service cohorts. On the basis of analysis of Medicare reimbursements for those who died during a year, the GAO calculated that payments should have been 5 percent lower to offset the measured biased selection.

Some cautions are necessary in the interpretation of the results from Medicare demonstrations. In the "capitation" demonstrations, there

were few sites, and HMOs were not as well known then as they are today. The fact that the risk contracts were for a demonstration period only may have discouraged some high users from enrolling. In addition, as a greater proportion of beneficiaries in an area enroll in private health plans, the enrolled population might resemble the general Medicare population more closely. The two studies of Minneapolis-St. Paul HMOs, though not on a Medicare population, are consistent with the hypothesis of healthier-than-average individuals enrolling in HMOs, however.

Some are reassured by the fact that the demonstration sites indicating biased selection were prepaid group practices, whereas most HMOs and CMPs offering risk contracts under current law are IPAs. Some project that IPAs, which are growing much more rapidly than PPGPs, will soon be the dominant form of HMO (Welch, 1986). Indeed, some IPAs are seeking to be released from their Medicare risk contracts because of heavy losses, for which adverse selection may have been a factor. Although this might be good news for those concerned about the Medicare budget, it provides little encouragement for the viability of the private health plan strategy, which depends on biased selection not overwhelming the effects of cost-containment efforts.

Research on Patterns of Use in Traditional Medicare

Nonexperimental research that is relevant to pricing under capitation has been conducted at HCFA with Medicare program data. It involves studies of patterns of service use by Medicare beneficiaries in the fee-for-service sector (Beebe, Lubitz, and Eggers, 1985). The research focuses on how much of the variation across individuals in Medicare claims is explained by the factors used in the AAPCC, and how much more is explained when other variables are added to the analysis. The variables used in the AAPCC explain a seemingly very small portion of the variance in utilization. When Medicare reimbursement per enrollee is the dependent variable, only 0.6 percent of the variation is explained. This is quite small when compared to a maximum of 20 percent of variation that Newhouse suggests could be explained by a set of observable variables (Newhouse, 1986).

The fact that the AAPCC variables explain only a small part of the variance in utilization does not imply biased selection, however. If groups of enrollees were randomly chosen, HMOs as a group would not have a biased selection of enrollees. But a low percentage of variation explained does increase the chance of biased selection playing a major role.

Biased selection results from asymmetric information. When either the beneficiaries or the health plans make use of information about likely use in their enrollment/marketing decisions that Medicare does

not use in setting rates, biased selection will occur. If additional variables were used in the AAPCC that increased the proportion of the variation in reimbursements per admission explained, biased selection would be reduced if the information contained in these variables removes an asymmetry that was causing the biased selection. Additional asymmetric information might remain, however.

Incorporation of additional factors into the AAPCC would also reduce risks to HMOs from random elements in the enrollment process. The higher the proportion of variation that is explained by the AAPCC, the lower the probability that an HMO will find itself with higher- or lower-than-average users by chance occurrence.

Nonexperimental research has examined the potential of additional variables to explain variation in the use of services, especially various measures of prior use and health status. The potential of prior use as an additional factor in the pricing algorithm is based on the assumption that a beneficiary with higher-than-average use of services in the recent past will tend to have higher-than-average needs in the present and possibly the near future. This notion of correlation of medical care use over time has received support in a number of studies using longitudinal data on the elderly (Roos and Shapiro, 1981; Anderson and Knickman, 1984; Eggers, 1981)

Recent research at HCFA has shown a significant improvement in the AAPCC from adding administrative data on the number of hospital days during the previous two years and whether the Part B deductible was satisfied in both years (Beebe, Lubitz, and Eggers, 1985). The proportion of variation in claims explained by the AAPCC increased from 0.6 percent to 4.6 percent. A recent analysis of Michigan data, which used different measures of prior use, reported an increase in the variance explained from 0.3 percent to 7.1 percent (Thomas and Lichtenstein, 1986).

Currently, a demonstration is testing the use of this measure to establish a capitation rate for an HMO seeking to enroll a population of "frail elderly." In the first month under the new formula, the HMO received one-third more than it would have under the current formula (Lubitz, 1985).

Ongoing research funded by HCFA is focusing on refining the prior hospital use variable by using diagnostic information to distinguish among hospitalizations according to their degree of predictiveness of future use. For example, a gall bladder removal might be of less significance in predicting future hospitalizations than an admission for chemotherapy. Promising results have been obtained when hospitalizations are divided into three categories (Ash et al., 1986).

Research indicates that health status variables also help explain variation in reimbursements. Thomas and Lichtenstein (1986) found that perceived health status—individual self rating of health status in comparison to their contemporaries—explained 2.6 percent of the variation, compared with 0.3 percent for those factors used in the AAPCC. An index of "instrumental activities of daily living" explained 3.9 percent.

Although methods to increase the explanatory power of the AAPCC are available, research on patterns of use in traditional Medicare by itself cannot tell us about the degree of reduction in biased selection that could be achieved with them. That assessment requires analysis of actual enrollment decisions, either in a demonstration or through monitoring of the implementation of a policy change.

Options to Reduce Biased Selection

Although biased selection poses a serious obstacle to the private health plan strategy, attractive options to reduce it are available, some of which could be implemented fairly rapidly. These options can be sorted into two groups. One would revise the AAPCC so that it is a better predictor of service use. This includes addition of variables such as prior use or health status, modification of variables such as the geographic adjustment, and omission of variables such as welfare and institutional status. The other option would allow actual use for enrollees in an HMO or CMP to affect the current period's capitation rate. We feel that the limited evidence on biased selection is sufficiently worrisome that HCFA should proceed with both interim improvements and research on longer-term modifications.

Prior Use. Adjustments for prior use of services appear to hold the greatest potential for significant improvements in the short term. As noted above, HCFA researchers have examined the relationship between hospital admissions and satisfying the Part B deductible in prior years and use. Once the administrative apparatus of access to a beneficiary's claims history was set up, each of the cells in the AAPCC could be split into a high-use and low-use segment.

A departure from the "rate book" approach to the AAPCC would permit the use of additional detail on utilization. Rather than using cells, a regression model could be estimated, with each enrollee's predicted use the basis for the adjustment. Thus, with the current AAPCC variables, reimbursements per enrollee would be regressed on age, sex, basis of eligibility, and welfare and institutional status. The county adjustment would continue as it is today (we discuss other modifications of this adjustment below).

Although a regression approach would not gain a great deal with the current variables, since most are binary variables, prior use and other continuous variables could be employed without a substantial loss of information that the ratebook approach would result in. Thus, a variable for claims in the previous year would be added to the regression, and the coefficient on that variable used to adjust the capitation rate.

The coefficient on claims in the prior year would be less than one. This is because claims for many types of acute episodes of illness would not have much predictive power for utilization in the subsequent year, or certainly much less than claims for the costs of chronic illness.

One problem with this approach is that the degree to which a beneficiary served in the fee-for-service system regresses to the mean may differ from that with which an HMO enrollee would have done so if he/she had remained in the fee-for-service system. For example if HMO enrollees had 10 percent lower use that their fee-for-service cohorts, we cannot assume that they would have regressed to the mean at the same rate. For example, the entire difference might have been in the degree of chronic illness. The most frequent explanation for the pattern of biased selection indeed focuses on the presence or absence of chronic illness, so there is a good chance that those high users declining to enroll will continue to be high users. Thus, using a coefficient from the regression described above would underadjust for biased selection.

The magnitude of the uncertainty concerning what coefficient to apply to a difference in prior utilization could be reduced if research could distinguish between acute and chronic problems that result in medical care use (Ash et al., 1986). Past claims might be categorized according to the degree of chronicity of the medical condition. A different coefficient would then be estimated for each category. In this way, prior claims for chronic illness would have more influence on the adjustment for prior utilization than prior claims for acute illness. Thus, the regression coefficients could be used directly for the adjustment without concern that HMO enrollees have a different mix of acute and chronic conditions than their fee-for-service cohorts.

The major problem with using information on prior utilization concerns its use for enrollees who are continuing in an HMO or CMP. Not only are Medicare administrative data not available, but using data on a beneficiary's experience in an HMO might be considered inequitable and give rise to undesirable incentives on the part of the HMOs.

The absence of administrative data would delay implementation of an adjustment but ultimately would not be a major obstacle. HMOs/CMPs could be required to report to HCFA the number of

hospital admissions (by DRG) and perhaps the number of physician encounters, weighted by a relative value scale.

The issue of confounding the medical needs of the enrolled population with efficiency on the part of the health plan in managing utilization is a more serious problem. If a plan's enrollees used 10 percent fewer services than predicted on the basis of other factors in the AAPCC, the plan may have had healthier enrollees or may have been relatively efficient in managing their care. By adjusting for prior utilization of longstanding enrollees, we risk sacrificing the incentives and rewards for efficiency.

Whether the incentives and rewards for efficiency are sacrificed will depend to some extent on the methodology used to make the adjustments. For example, if a plan's new enrollees had in the previous year claims 10 percent lower than their fee-for-service cohorts, the methodology described above would lead to an adjustment smaller than 10 percent. Lubitz, Beebe, and Riley (1985) develop an example of how, under a model using the number of hospital days in the last two years and whether the Part B deductible was met in both years, an HMO would receive $4880 in 1985 for enrolling a 70-year-old nonwelfare male living in the District of Columbia who had been in the hospital for 10 days and satisfied the Part B deductible. The HMO would get $3811 for the same person with no hospital days. But $1069 would not go that far toward covering the cost of a 10-day hospital stay. Clearly, such incentives would affect only cases where the decision to hospitalize is a very close call.

Another way of incorporating prior utilization into pricing would involve establishing a threshold for including enrollees' utilization in the adjustment. An assumption behind use of a threshold is that those with large amounts of use are more likely to be chronically ill. Another consideration is that utilization management may be most effective for patients with more modest amounts of use, so that incentives would be interfered with less than under a scheme adjusting for the use of all continuing enrollees. This idea might be best carried out as a retrospective adjustment (discussed below). Alternatively, if adjustments were based on prior hospital admissions, clinical judgment could sort DRGs into categories for which physicians have extensive or limited discretion concerning whether to admit (Ash et al., 1986).

Another approach would use prior utilization only for the first few years of a beneficiary's enrollment in an HMO/CMP. By using data on use before enrollment, it would avoid the incentive/reward problem entirely and probably solve much of the adverse selection problem. On the basis of a beneficiary's use in the last year—or few years—in the fee-for-service system, a declining schedule of adjustments would be

derived. The rate of decline would be determined through the regression model that provided the adjustments. HMOs/CMPs would still have incentives to encourage an enrollee with chronic illness to leave, but the incentives would be no greater than those under current procedures.

During the next few years, the bulk of HMO/CMP enrollees will be recent enrollees, for whom relatively recent prior utilization data will be available. Those enrolling in private health plans without Medicare fee-for-service experience (for example those enrolling upon attainment of Medicare eligibility) will be a sufficiently small proportion of plan enrollments that omitting a prior utilization adjustment for them would not be a serious problem. By the time that a large proportion of enrollees have been served by private health plans for some time or do not have prior Medicare fee-for-service experience, additional adjustments such as one for health status are likely to be operational. They are discussed below.

Newhouse (1986) has suggested the use of current utilization as a factor in the capitation rate. This amounts to a blend of capitation and fee-for-service payment. Although such a blend clearly reduces incentives to limit the use of care, this might be a good thing, since pure capitation incentives could result in underprovision of services.

Subsequent Use. Less is known about biased selection in disenrollment, but an adjustment for *subsequent* utilization might have particular usefulness as a quality control mechanism. Some are concerned that instances of low quality of care would become apparent to patients only when seriously ill. Although Medicare permits disenrollment on relatively short notice, such behavior on the part of beneficiaries could reward HMOs for poor quality service by having the fee-for-service system or another HMO bear the costs of complications.

Besides acting as a quality control mechanism, adjustment for utilization after disenrollment could prevent a potential subtle selection strategy of having very appealing services that relatively healthy beneficiaries would use (personable primary care physicians offering preventive services) but scrimping on specialty services and hospital care. If the chronically ill were induced to disenroll through dissatisfaction with care, plans would have succeeded at "cream skimming."

Presuming that most of those disenrolling would return to the fee-for-service system, a subsequent adjustment to the health plan's capitation payment could be based on subsequent use of services by disenrollees. To reduce costs of administration, the adjustment would be applied only when the proportion of a health plan's membership disenrolling exceeded a threshold. This approach would be similar to the waiver of liability used in claims review.

Will More Information Reduce Biased Selection? Some have criticized the approach of using additional variables such as prior utilization to modify the AAPCC. The concern is that the larger variation in payment rates by category of persons would increase opportunities on the part of health plans to "game the system" by seeking to attract those with lower probabilities of use than others in the category (Milliman and Robertson, Inc., 1983). For example, if a category was established for persons with prior hospitalization, plans might then seek persons with a hospitalization for an acute rather than chronic illness. Proponents of this point of view argue that opportunities to seek enrollees who had prior hospitalizations for acute conditions would be greater than those under a cruder system to avoid persons that had been hospitalized.

We are doubtful about the merits of this criticism, which logically should apply to the existing AAPCC factors as well. In essence, the criticism implies that if 85-year-olds get a higher capitation rate than 65-year-olds, then the returns from enrolling a healthy 85-year-old would be greater than under a system that did not vary the capitation rate with age. Although there may be some instances where this is the case, removal of the incentives to enroll 65-year-olds but not 85-year-olds will reduce the degree of biased selection overall.

The same argument is relevant to prior use variables. Although an opportunity is developed to seek out persons hospitalized for acute or self-limiting conditions, the removal of an opportunity to seek out only persons that have not been hospitalized is likely to be more important.

The issue that these critics appear to be raising is one of homogeneity within category. The less homogeneous are pricing categories, the greater the opportunities for selective marketing on the part of health plans. But careful refining of AAPCC categories will increase rather than reduce this homogeneity. One should examine each new category for the degree of homogeneity and reject refinements that would create highly heterogeneous ones—such as institutional status (see below)—but not reject the entire approach to refinement.

Use Prior Disability Status. Whether a beneficiary had been eligible for Medicare on the basis of receipt of Disability Insurance is a useful predictor of service use. Lubitz, Beebe, and Riley (1985) report that previous receipt of Social Security Disability Insurance is associated with higher rates of use long after attainment of age 65. For example, men aged 75 and over who had received Disability Insurance in the past had Medicare reimbursements 40 percent higher than the average for their age group. Previous receipt of Disability Insurance could be added to the AAPCC with only minimal additional analysis.

Discontinue Institutional and Welfare Status Adjustments. Institutional status might be dropped as an adjustment in the AAPCC. A variety of problems are associated with its continued use.

First, rates of institutionalization vary dramatically from county to county, reflecting not so much variation in health status but substitution of home health services for nursing home care. The national adjustment used is bound to cause geographic inequities across counties.

Second, the incentives caused by the use of such a distinction strongly encourage institutionalization. HMOs have the incentive of a higher capitation rate to refer those in need of long-term care to nursing homes. Since long-term care is not a Medicare benefit (and is not an extra benefit that HMOs offer), HMOs are not at risk for such costs.

If a prior use adjustment were incorporated, much of what an institutional adjustment accomplishes would have already been taken into account. The adjustment would reflect the higher costs of both those who are institutionalized and those with chronic disease but remain at home.

The problem with the welfare status adjustment is one of heterogeneity within the class. It includes both the categorically eligible and the medically indigent. The latter have incomes that are too high to qualify for cash benefits, but when large medical expenditures are subtracted from their incomes, the remaining income is low enough for Medicaid eligibility. This leads to substantial overpayment to health plans that serve those receiving welfare benefits whose eligibility is not based on medical indigent status. Use of prior utilization would accomplish much of what the welfare status adjustment is intended to accomplish.

Change the Geographic Unit. Many feel that the county is not an appropriate geographic unit for capitation pricing. For rural counties, small sample sizes are a problem. In urban areas, inequities arise when a county is partly urban and partly rural, but the HMO draws all of its enrollees from the urban part of the county. In multicounty urban areas, a health plan may draw enrollees from counties with divergent AAPCCs but treat its patients without regard to county of origin (Hornbrook, 1984). (The incentives inherent in this phenomenon—that HMOs market in counties with the most expensive fee-for-service medicine—are desirable. Capitation should be used most in areas where it has the greatest potential.)

Milliman and Robertson (1983) have suggested use of three-digit zip codes instead of counties. The former are much larger; there are 770 in the country in contrast to over 3100 counties and equivalents. Since zip codes were constructed to reflect cultural, economic, communication, and transportation patterns, they are likely to reflect medical care

delivery patterns better than county boundaries. This consolidation would be particularly valuable in rural areas.

Health Status Adjustments. For the intermediate term, inclusion of variables on health status has potential. In the same way that DRGs adjust for the expected resource needs of hospital patients under the Medicare Prospective Payment System, an appropriate health status index can reflect an enrollee's expected annual resource needs. Unlike health status indexes that have thus far been developed by researchers to measure the impact of health services use on health, or to characterize the overall health of an area's population, one that is useful for pricing would have to be designed to predict use of medical services accurately. To be operational, such an index would also have to be reliable, not subject to manipulation by providers, and require only data that were inexpensive to collect (Thomas et al., 1983).

Three types of data are candidates for developing such an index—perceived health status, functional health status, and physiologic measures. Perceived health status is based on questionnaire responses by individuals who self rate their health relative to that of contemporaries. It has been used in health services research extensively and has established strong validity as a predictor of health services use. It is reliable and inexpensive to collect. The major uncertainty concerns possible bias on the part of the respondent. Will the respondents feel that indicating better or poorer health will affect their access to medical services? Can physicians influence responses, either intentionally or unintentionally?

A recent study by Thomas and Lichtenstein (1986) indicated that perceived health status was a much more powerful predictor of health service use among the Medicare population than the current AAPCC factors. A single item scale explained 2.6 percent of variation in payments per enrollee, compared with 0.3 percent explained by the AAPCC factors.

Measures of functional health status focus on capabilities to perform certain actions. Examples are indexes of "activities of daily living" (ADL), and of "instrumental activities of daily living" (IADL). The former concentrates on ability to manage personal care; the latter concentrates on more complex activities. Functional status measures are more objective than perceived health status, and the degree of validity in predicting health services use may be higher than perceived health status. The abovementioned study found that the IADL explained 3.9 percent of the variation in payments, but the ADL explained only 1.3 percent. The latter did not have sufficient variation within the general Medicare population.

Physiologic measures, such as blood pressure, ECG abnormalities, chronic joint symptoms, and weight-height measures, have the advantage of objectivity and difficulty in manipulation by providers, but their validity in predicting use has not yet been tested. The RAND Health Insurance Experiment used about 30 physiologic measures to measure the effects of cost sharing on health status. This database is available to assess inexpensively which measures are valid for use in capitation pricing. Should encouraging results be obtained, HCFA could then initiate research on validity for the Medicare population. Because many of these measures are available from medical records, elaborate data collection procedures might not be required. Health plans might be required to report such data, with HCFA performing spot checks on accuracy.

Whatever measures are used, periodic data collection would be required, if only to remove incentives to dump those enrollees whose medical care needs have increased (McClure, 1984). Repeated observation of health status also opens the possibility of employing data on changes in the health status of enrollees. For example, health plans might be rewarded with incentive payments for improvements in health status of continuing enrollees. Publication of changes in health status not only might increase incentives for quality care but also might offset any incentives on the part of providers to report a lower health status to increase reimbursement.

As the reader can surmise, a health status adjustment is not feasible at this point of time. Not only is more development required to design a measure that would be appropriate for pricing of capitated services, but the necessary data will have to be collected. Nevertheless, a research program should begin now, with analysts not limiting themselves to data that are already available to HCFA. If capitation is to play a major role in Medicare, more accurate pricing than is possible today will be needed, and collection of additional data is an important requirement for better pricing. Medicare did not hesitate to collect highly detailed cost data from hospitals when the mode of payment was cost reimbursement. If payment is to be on a capitation basis, accurate data reflecting the health service needs of different groups of enrollees is needed.[1]

Retrospective Adjustments. An alternative to using additional AAPCC factors such as health status is partial retrospective

[1]We acknowledge that improving pricing data will cost money, and that the only evidence that biased selection is now a serious problem in Medicare is for the most part anecdotal. Nevertheless, the probability of biased selection is high enough, and the risks to a successful capitation program large enough, that beginning research now is the appropriate approach.

adjustment to reflect actual experience. Clearly, the use of actual experience must be approached cautiously, lest the private health plan strategy become one of cost reimbursement. One proposal along these lines that is worth exploring would have mandatory reinsurance for catastrophic cases underwritten by Medicare (Milliman and Robertson, 1983). Under this approach, Medicare would reimburse the plan for some percentage of expenses incurred for an enrollee beyond a certain threshold—for example, 80 percent of expenses that exceed $4000 per year. The premium for such reinsurance would vary only by the plan's AAPCC. Thus, plans with a sicker-than-average enrollment within AAPCC categories would collect more in reimbursements than they would pay in reinsurance premiums, with the opposite occurring for those plans enrolling a healthier-than-average population.

The rationale behind such an approach is that the health plan has little control over whether a patient will have catastrophic expenses, so that the reinsurance would not interfere with cost-containment incentives or be unfair to plans with the most effective management of costs. But this is unlikely to be the case. The recent case study comparing patients of teaching physicians with those of community physicians at Stanford Hospital indicates the potential for variation in practice style concerning patients who are very ill (Garber, Fuchs, and Silverman, 1984). We have little information concerning which types of patients allow HMOs the greatest success in containing costs. It is possible that HMOs are very effective with patients having large expenses, and that good management can reduce many $6000 cases to $4000 cases. Thus, one would not want to reduce incentives for patients with expensive illness to a significant degree.

A host of technical issues would have to be resolved. Reporting requirements for health plans concerning charges or costs might be extensive. Would physician charges have to be screened for reasonableness? Although smacking of extensive regulation, the need to resolve all of these details is no different from what private reinsurers must do to write policies for HMOs. The norms developed to write these policies could be used by Medicare to resolve many of these issues.

Another option that would use retrospective experience would adjust capitation rates on the basis of mortality experience (Manton and Tolley, 1985). It is well known that a substantial portion of Medicare claims is for beneficiaries in their last year of life. Lubitz and Prihoda (1984) estimated that in 1978 decedents constituted 6 percent of the Medicare population but 28 percent of claims. Thus, paying HMOs that have higher cause-specific mortality rates than experienced in the fee-for-service population in the area would offset a portion of biased selection.

Such a proposal, however, would likely be a disaster from a political perspective. With quality of care becoming one of the most controversial Medicare issues, few public officials would want to be in the position of advocating a scheme that gives health plans incentives to allow their members to die. It would penalize those plans that use additional resources to reduce mortality.

Conclusion. The evidence now available suggests that biased selection is a sufficiently serious threat to the private option strategy that interim steps are called for. We recommend that administrative data on prior use be employed now to modify the AAPCC. The adjustment should be used for those enrolling from the fee-for-service system and should continue for a few years with the magnitude of each enrollee's adjustment declining over time. As continuing enrollees become a larger part of HMO/CMP enrollment, prior use should then be phased out in favor of a health status measure.

AGGREGATE LEVEL

The rationale behind the current approach of basing the capitation rate on costs incurred by Medicare on behalf of beneficiaries using the fee-for-service system is that private health plans should compete with traditional Medicare (as well as each other), and that most of the savings from such plans' efficiencies in medical practice ought to accrue to the beneficiaries who enroll in them. Consequently, although many projected HMO/CMP savings of 15–25 percent compared to traditional Medicare, all but 5 percentage points was left to the beneficiaries and the health plans. If the projected savings materialize, and if either the premium regulations in TEFRA or competition among health plans leads to their being passed along to beneficiaries, incentives to enroll in private health plans will be strong.

Capitation Rates during the Early Stages of the PHPO

Creation of a large enrollment incentive is a critical aspect of a private health plan option strategy. Only 3 percent of the Medicare population is now enrolled in private plans, and incentives to beneficiaries are necessary to achieve a rapid increase in enrollment.[2] Incentives for health plans to serve the Medicare population on a risk basis

[2]Little research is available on sensitivity of enrollment choice to premium differences between HMOs and fee-for-service plans. The only attempt to measure this that we are aware of is an unpublished study by Welch (1984), which estimated the long-run own-price elasticity for HMOs at −0.6 and the cross-price elasticity for conventional insurance at 0.5.

are also important, and as we discussed above, in the section on regulation of premiums and profits (Sec. IV), may be too small.

So long as the federal government pursues rapid increases in enrollment in private health plans, potential budget savings will be limited. With enrollment a voluntary decision, beneficiaries will have to retain a substantial part of the savings from participating in a private health plan if more are to enroll. Only if HMO/CMP savings turn out to be substantially higher than has been projected could the federal government reduce the payment rate substantially below 95 percent. Otherwise, incentives would be reduced substantially, and the market share of private health plans would grow more slowly. Reducing the payment rate would be especially inadvisable now, when enrollments are low, because few dollars would be saved and the Administration's PHPO strategy would be seriously threatened.

Capitation Rates Once Enrollment Is Substantial

Should the private option strategy be successful in enrolling a substantial proportion of the Medicare population in private health plans, however, the method for setting the aggregate payment level might be revamped. If private health plans become the "mainstream" method of organizing the delivery of medical services to the Medicare population, the Congress might reconsider basing capitation payments to such plans on the experience of a "residual" traditional Medicare. Needless to say, however, the definition of "substantial" would require considerable judgment. It might be in the 25–50 percent range, however, perhaps applied on a market-by-market basis.

Should private health plans achieve such high enrollment that they are considered the "mainstream" delivery mode for Medicare, the Medicare entitlement might then be defined on the basis of premiums charged Medicare beneficiaries by private health plans. Instead of an entitlement to an array of benefits delivered on a fee-for-service basis, the entitlement would be to the same array of benefits when delivered by a private health plan. For those preferring to continue with traditional Medicare, a premium would be charged, reflecting the costs associated with it.

Discussing the aggregate level of payment in terms of how to define the Medicare entitlement does not preclude general budget considerations from playing a role as well. Although the enactment of Medicare reflected a desire to provide access to health services and protection from financial setbacks associated with medical care use, the precise amount of subsidy needed to fulfill these goals is subject to interpretation. Indeed, budget considerations have played a role to date. The

proportion of Part B outlays underwritten by beneficiaries' premiums has already been altered twice—in 1972, when the proportion was allowed to fall as Social Security benefits grew more slowly than Part B outlays, and then in 1982, when the proportion was fixed at 25 percent (half of the original 50 percent) on a temporary (but still continuing) basis. Basing the magnitude of the Medicare entitlement on the experience of beneficiaries in private health plans might facilitate the incorporation of budget considerations, a belief that in the past has led some organizations to oppose voucher proposals, even voluntary ones.

If Medicare payments came to be based on beneficiaries' experience in private health plans, important budget savings could accrue to the federal government. The magnitude would depend on the degree of efficiency relative to traditional Medicare that private health plans achieve. Of course, through the federal approach, traditional Medicare is becoming more efficient, so the budget impact of the private option strategy may be less than the cost difference between HMOs and traditional Medicare today. Indeed, with a very aggressive federal approach—a likely course given the long-term budget pressures on Medicare—costs of private health plans need not be lower than Medicare fee-for-service reimbursements. Budget savings would then come from the federal approach, rather than shifting the basis of the entitlement to the experience of private plans.

Higher costs than Medicare need not imply a lack of success by private health plans. Many beneficiaries might prefer them to a highly constrained Medicare—for example, if access to popular providers were better in the former. Similarly, physicians might contribute to private plans' success under this scenario by accepting lower revenues to avoid dealing with Medicare on a per service basis.

A variety of methods exist to set capitation payment rates on bases other than the experience of those beneficiaries remaining in traditional Medicare. They could be based either on premiums charged beneficiaries by qualified private plans or on costs experienced in traditional Medicare at the time of conversion, updated by a trend factor reflecting general inflation and cost impacts of technological change.

Private Plan Premiums. Basing the capitation payment on the premiums of HMOs and CMPs for basic Medicare benefits would be most consistent with Medicare's traditional role in providing a service benefit (for example, the costs of the second through sixtieth day of a hospitalization during a spell of illness). Beneficiaries would be assured that the capitation payment would be sufficient to pay for the benefits that they are accustomed to, as long as they obtain them through an efficient private health plan.

Implementing this principle would require a number of specific policy decisions. For example, should the median premium be used, some lower percentile, or the mean? Should the rate be based on premiums in the beneficiary's market area, or on premiums across the nation, which in turn are adjusted for local factors such as wage rates?

Hiding behind these seemingly "technical" policy decisions are broader, more philosophical issues. For example, by using private plans' premiums to set the capitation rate, beneficiary choice of amenity levels would influence the rate. If beneficiaries opted for plans with higher levels of amenities (or higher levels of quality, presuming that quality and price are related), then capitation rates would be higher. This would be partially consistent with Medicare's longstanding policies—cost reimbursement for hospital care and paying physicians' actual charges subject to screens—but with far more suitable incentives.

But one could pursue an alternative principle that the taxpayers should pay only for a minimum standard of care, with beneficiaries free to pay more for a more expensive mode of medical services. This could lead to the choice of a lower percentile than the 50th.

The question of national versus local basis for rates involves similar issues. Substantial geographic variation in practice patterns and fee levels exists today. Should capitation payments ratify these variations? The traditional Medicare policies have done so, but many would argue that the nation's taxpayers ought not support the relatively high fee levels or expensive practice styles of certain geographic areas. Variation in fees and practice patterns may be a reflection of the previous unconstrained system, where physicians had little reason to question whether a more expensive method of treatment was worth the extra cost, and patients had little incentive to shop for physicians with lower fees or more conservative practice patterns.

National rates would mean an end to the subsidy of expensive practice styles in some areas by taxpayers in others. If residents in high-cost areas chose to maintain expensive medical care, they would be free to do so through contributing their own funds to pay the difference between the Medicare capitation amount and premiums charged. If they balked at this, strong competitive pressures on health plans would force fee levels and practice patterns toward the national average. National rates would tend to increase costs in plans in areas with low rates of medical spending unless rebates were permitted, in which case some of the upward pressure would be removed.

The magnitude of these forces is not clear, however. Unlike the case of hospital reimbursement, where Medicare is so dominant in the market (responsible for close to 40 percent of patient revenues), the upshot of national capitation rates could be large out-of-pocket premium payments by beneficiaries in high-cost areas. The degree to which practice patterns and fee levels change would be based principally on the behavior of private payers.

VII. RESEARCH AND DEMONSTRATIONS

HCFA-sponsored research and demonstrations are an integral part of the private health plan option strategy. These efforts are needed to provide information on likely responses to program changes, to identify current problems with capitated arrangements, and to develop the parameters with which to administer a capitated system. In addition, HCFA could underwrite research not directly linked to its policy decisions—for example, research that might be used by private health plans in managing medical care services provided to Medicare enrollees.

Some of the issues that research and demonstrations may shed light on include:

- What is the extent and pattern of biased selection in enrollment in HMOs/CMPs?
- What are the cost savings achieved by HMOs in serving the Medicare population? How are these savings achieved? Do IPAs reduce costs in different ways than staff or group model HMOs?
- To what extent does the current regulation of premiums and profits limit health plans in decisions such as pricing, marketing, and benefit design?
- What have been the factors behind HMOs/CMPs' choice of markets in which to serve the Medicare population?
- What marketing techniques have plans found most successful? How much is spent on marketing? How much of this expenditure goes to educate beneficiaries about private health plans as compared to informing them about the relative merits of a particular plan?
- How does the quality of care in HMOs/CMPs compare with that received by Medicare beneficiaries in the fee-for-service system? Is there more variation from one plan to another than among fee-for-service providers?

In addition to these research questions, a number are directly linked to demonstrations—for example, what would be the effects of capitation of the health plans of large employers? These are discussed below in a section on future demonstrations.

PAST AND ONGOING RESEARCH AND DEMONSTRATIONS

Much that has been completed or is well under way has been discussed in the previous sections. Here, we simply pull it together, focusing on the types of research that have been pursued. Although the general research on HMOs is voluminous, we have limited this discussion to work dealing with Medicare enrollees in HMOs.

Much of HCFA's research on HMOs and CMPs has been based on three series of demonstration projects—the Medicare Capitation Demonstrations, the Medicare Competition Demonstrations, and the Social Health Maintenance Organization (S/HMO) demonstrations. Initiating such demonstrations has been a well-advised research strategy, since the experience of Medicare beneficiaries in HMOs is likely to be different from the enrolled non-Medicare population.

The "capitation" demonstrations, which began in the late 1970s, increased our knowledge about biased selection by examining prior use of both the enrollees and their fee-for-service cohorts. Ongoing research is examining utilization experience during the demonstration. Whether it will be able to distinguish among enrollees regressing to the mean, the effects of the HMOs' utilization management, and prior unmet needs is unclear.

Although a report on the implementation of the Medicare Competition Demonstrations, which began in 1982, was recently submitted to HCFA, analytic results are not yet available. A rich set of results is anticipated, however. The numerous plans involved should facilitate the analysis. The questions to be answered are extensive, and results should be very valuable. The risk contracts were similar to those under Section 1876 today, so many of the results should be especially applicable. The evaluation is also to cover some of the period in which the demonstration contracts were converted to comply with Section 1876 regulations.

More recently, HCFA initiated an especially ambitious demonstration of S/HMOs and has awarded an evaluation contract. This demonstration is especially important because it will test a combination of private financing of long-term care, its provision under capitation, and the integration of long-term care and acute care services.

HCFA is also supporting demonstrations of the provision of information about health plans by consumer organizations. One such demonstration is a controlled trial of the effect of information programs on beneficiaries' health plan choices. The demonstration is testing alternative methods of providing about-to-be-entitled beneficiaries with information about the consequences of various choices they will face,

such as purchasing supplementary insurance, joining an HMO, and choosing a participating physician. The evaluation will compare the subsequent choices made by the random sample of beneficiaries exposed to the information program with the choices made by similar beneficiaries who were not exposed.

Although these three demonstrations are providing substantial information on prototypes of the private health plan option strategy, research on the Medicare History File and other HCFA databases has been providing valuable information needed to guide refinement of the AAPCC—one of the highest research priorities. This type of research has been supplemented by primary data collection to examine the improvement in the explanation of variation in use from the addition of health status variables. Results from this research were discussed in Sec. VI.

FUTURE RESEARCH

Research into a number of areas would be helpful to the private health plan option strategy.

Program Evaluation

Perhaps the highest priority should be accorded a broad program evaluation of Section 1876 contracts to date. HCFA needs to monitor the experience with risk contracting closely to detect problems early. The program evaluation should focus on biased selection, cost reduction, the quality of care, marketing practices, and other relevant issues discussed above. Although a great deal of valuable descriptive information would be generated, analysis will not be easy because of the way risk contracting was implemented. With risk contracts available to all health plans simultaneously, the ability to make comparisons across market areas is precluded. The evaluation will instead have to rely on comparisons between the experience of a health plan and the fee-for-service system in its area, separating out biased selection where possible.

HCFA already has much of the data with which to conduct such a program evaluation. It gets extensive data from the HMOs/CMPs as part of the plan qualification process and the regulation of premiums and profits. Of course, data on the fee-for-service population are available, though additional efforts must often be made to build files that are suitable for research.

Anecdotal information on Medicare beneficiaries' experience with HMOs/CMPs is certain to be plentiful. To date, most of it has concerned the experience of International Medical Centers in Miami. If the public and their leaders are to have an accurate assessment of the entire experience with private health plans, HCFA needs to undertake a comprehensive program evaluation.

General Research on Health Plans

Although a program evaluation is being conducted, HCFA may wish to pursue additional research on health plans in general—irrespective of their role in Medicare. By expanding our knowledge of how different types of HMOs operate, we will be in a much better position to guide Medicare's capitation policies.

An area of research that would be particularly fruitful would be to investigate how IPAs control utilization and costs. IPAs have changed dramatically since the mid-1970s. They have instituted utilization controls, and many have devised methods of sharing capitation risks with member physicians. Increased knowledge of IPA operations would be useful not only for capitation policies but to see which operations might be adaptable to traditional Medicare. Some employers have eschewed HMOs in favor of introducing utilization control procedures into their basic health plans.

Development of Instruments and Procedures to Measure Health Status

Much of the research on health status has focused on uses other than payment. Section V outlined three types of health status measures—functional status, perceived status, and physiologic status. Preliminary results on the first are highly encouraging. Further development work and testing of all three approaches might be pursued.

Development of Quality Control Mechanisms for HMOs

As competition has become a more central part of the health care system, policymakers have begun to focus more attention on the quality of care. As we described above, there is a strong basis for hope that costs can be reduced without a major sacrifice in quality, but for this to occur, individual health plans will have to be skillful in their approaches to cost containment. Any sacrifices in quality can be reduced if HMOs have more effective mechanisms to control quality.

HCFA might speed the development of quality control mechanisms that would be useful to HMOs by supporting development efforts and disseminating the results.

Quality of Care in HMOs

Although quality of care was one of the items mentioned in the discussion of a comprehensive program evaluation, such research is so important that we wish to raise it separately. It might be pursued separately from a comprehensive program evaluation because the research skills required are highly specialized. For each of a sample of HMOs with large enough numbers of Medicare enrollees, a matched sample of beneficiaries in fee-for-service Medicare could be drawn. In addition to the usual matching parameters of age, sex, and income, use of medical care in a year prior to HMO enrollment could be employed.

FUTURE DEMONSTRATIONS

Some of the questions raised throughout this report are answerable only through demonstrations. For example, if Medicare contracted with employers on a capitation basis, would beneficiaries be better off? More can be learned about geographic capitation only through a demonstration. But demonstrations are expensive and time consuming, so care must be taken in deciding when to initiate them.

The most promising areas for demonstrations are large policy changes where the uncertainty about effects is too large to responsibly implement the change nationally. In some cases, the uncertainty will be universally appreciated; in others, some will be confident enough about the benefits to proceed without a demonstration but enough others remain to be convinced.

In other cases, likely effects are relatively certain, and demonstrations would waste time and money. An example of this would be coordinated open enrollment. Even when there is ample uncertainty regarding some outcomes, demonstrations should be avoided in cases where policy changes have been blocked because of political opposition resulting from relatively certain impacts.

An intermediate case would be where uncertainty is substantial, but the costs of demonstrations are somewhat lower because the policy change would proceed slowly in any case. For example, in employer capitation, the number of large employers prepared to experiment with it is small enough that proceeding with a demonstration would not delay progress in making use of the concept.

In keeping with the theme of this report, our suggestions for future demonstrations focus on options to deregulate Section 1876. Demonstrations would remove various restrictions on private health plans to assess whether the restrictions are serving their stated purpose.

Because an important element of the private health plan option strategy is competition among health plans, the general approach to a demonstration program should focus on market areas. It makes little sense to suspend premium and profit regulation for a single HMO when its competition remains constrained. The demonstration instead must change the regulation for selected market areas and not for others. Then, an evaluation could focus on differences between market areas.

Careful choice of market areas—both experimental and control—will be important to success in evaluation. Temptation to choose experimental market areas on the basis of volunteers should be resisted, lest the experimental markets have some distinct characteristic that is not matched in the choice of control markets. An exception would be random choice among markets where many organizations have sought a demonstration, with the markets with volunteers not chosen serving as controls. In this way, any unobserved characteristic associated with volunteering would then be present in the control as well.

We review nine options for demonstrations in this section. Some appear to have merit, but others clearly do not. We nevertheless discuss the latter as well, since interest in them has been evident. The nine options are:

- End premium and profit regulation; permit cash rebates to the beneficiary.
- Broaden the scope of eligible organizations.
- Waive open enrollment provisions for some employment-based plans.
- Capitation for Part B only.
- Increased publicity for HMOs/CMPs supported by HCFA.
- Voucher to the beneficiary.
- Refinements to AAPCC.
- Mandatory voucher.
- A Medicare PPA.

As we will discuss below, the first and third demonstrations appear to have the highest priority. Discussion of the last is reserved for the following section.

End Premium and Profit Regulation

A demonstration would suspend premium and profit regulations and permit cash rebates to the beneficiary in chosen market areas.

Questions that such a demonstration might provide answers to include:

- Would plans substitute cash rebates for optional services?
- Would premiums (adjusted for the actuarial value of the benefit package) increase relative to those under current policy?
- Would more plans seek to contract with Medicare on a risk basis?
- Would beneficiaries be more satisfied with the range of their health care options?

Because the focus of the demonstration would be on health plan response to a less regulated environment, the demonstration would have to run for a lengthy period (three or four years). Otherwise, health plans might not bother to respond to the temporarily different regulatory environment. Evaluations could begin to obtain results relatively early however, as plans would probably implement changes as soon as possible.

Although plans might adjust their benefit packages and premiums during a lengthy demonstration, we should not be sanguine about the prospects for influencing entry into the experimental market area. Start-up costs are too high for an organization to allow much scope for a demonstration to influence plans for entry into a market.

The demonstration should be conducted both in markets where competition among private plans is well developed—Minneapolis-St. Paul and Miami, for example—as well as in relatively undeveloped markets. Such deregulation might be particularly important for undeveloped markets, since new competitive plans are likely to have the most problems with existing premium and profit regulations.

Such a demonstration might face some political opposition from both HMO traditionalists and Medicare traditionalists who insisted on these regulations before agreeing to the enactment of Section 1876. However, attitudes have evolved in the four years since enactment of the legislation, with more general support for market approaches to health care cost containment. In addition, there is increased awareness concerning both the obstacles to health plans and the loopholes in the present regulations. The difficulties in resolving some of these problems might make skeptics more receptive to suspending the regulations.

Broaden the Scope of Eligible Organizations

Another demonstration could test the applicability of the Medicare private health plan strategy to plans excluded by Section 1876's requirement that physicians' services be provided primarily by employees of the organization or through physicians under contract. This requirement has to date excluded indemnity insurance plans.

Two types of indemnity plans have the potential to compete with Medicare. One would be a plan with a PPA component. In these plans, the beneficiary decides on a service-by-service basis whether to use a PPA provider and is rewarded with lower cost sharing for doing so. The insurance plan can afford the lower cost sharing from discounts received from the preferred providers, a relationship with the providers that permits more effective utilization review, or selection, of low-cost providers. HCFA's Office of Demonstrations and Evaluations might solicit initiatives from PPAs.

A second candidate would be an upscale insurance plan. Such a plan would use relatively high screens for physicians' fees so that beneficiaries choosing high-priced physicians could do so without large out-of-pocket payments at the time of service. Such plans would have great difficulty competing with Medicare, however, unless they were given the same ability to purchase hospital care through intermediaries that HMOs/CMPs have.

A broadening of plan eligibility requirements would require revisions in the requirements for access to care. With indemnity type plans, access is related to how high the reimbursement rates are rather than the number of physicians under contract. One possible revision, applying to plans that do not meet the current law requirement concerning the proportion of care delivered by physicians who are employees of the plan or under contract, would drop the access requirements for those plans that pay at least as much as Medicare to a certain percentage of physicians in the area. This would assure that access was at least equal to that in the regular Medicare program.

Questions to be answered through such a demonstration include the ability of indemnity plans to compete with Medicare, on the one hand, and HMOs/CMPs on the other. If they were successful in enrolling beneficiaries, the next question would concern the experience of the beneficiaries with the plans. Do they feel that the plan is a significant improvement over the plan they were in before? Finally, the degree and direction of biased selection introduced by the addition of indemnity plans is of substantial concern.

Political opposition to this option is unlikely to be great. Those aspects of plan qualification that protect beneficiaries would be

retained, so consumer protection issues are unlikely to arise. When TEFRA was enacted, indemnity plans appeared to offer little advantage over regular Medicare. With traditional insurers not pushing to be included, there was no opposition to their exclusion.

Given that offerings by private PPAs appear to be legal under current regulations (or made so by HCFA) and that traditional insurance plans are unlikely to be able to compete with Medicare, neither of these demonstrations should be accorded the highest priority by HCFA. HCFA might instead take a passive stance. Instead of choosing market areas to reduce regulations, it might follow its more traditional approach of responding to proposals for demonstrations from interested private parties. For those appearing to be attractive, HCFA might grant a waiver and fund a limited evaluation.

Employment-Based Plans

During the past few years, some employers have achieved substantial success in containing health care costs through changes in their basic health plans. An important focus has been the application of management to health benefits, such as utilization review and directing employees to efficient providers. If Medicare beneficiaries could enroll in their former employer's plan, the proportion of Medicare beneficiaries enrolled in private plans with potential for cost containment might increase substantially.

Allowing access to employment-based plans would require three changes. First, the open-enrollment requirements would have to be waived. Most employers would want to restrict membership to their own workers and retirees. Second, requirements concerning the provision of physician services by those under contract would have to be relaxed. We would not want to exclude indemnity plans that could compete with Medicare on the basis of superior utilization management but that had few restrictions on which physicians could be used. Third, consistent with our recommendations for HMOs/CMPs, premium and profit regulations would be suspended. The 50 percent maximum on Medicare enrollment would be maintained.

One issue to be addressed is whether employment-based plans could purchase hospital services for Medicare enrollees through fiscal intermediaries, or pay hospitals directly on the basis of Medicare rates. Some argue against such a practice. Many have had second thoughts about the initial decision to allow HMOs/CMPs to do so, and expanding the privilege would make it more difficult to ultimately remove it. Those employers willing to influence their employees' choice of provider, for example through the use of PPAs, have been able to purchase hospital services at substantial discounts.

HCFA would have to pay particular attention to setting an appropriate capitation rate. Those with long enough work histories to qualify for an employer's retirement benefits may be in better health than their cohorts. On the other hand, their comprehensive health insurance may have led to habits of using medical care more extensively. Relative health service use is also likely to vary by industry on the basis of occupational factors.

Employers are likely to be well aware of how rates of utilization of their retirees compare to the AAPCC. Thus, if the capitation rate were simply based on the AAPCC, those employers whose retirees have lower rates of use than the AAPCC would be much more likely to approach HCFA to volunteer for such a demonstration.

HCFA does have the resources to resolve the problem, however. An employer seeking to negotiate a capitation agreement should be required to forward to HCFA a tape with the Social Security numbers of retirees to be covered. Since HCFA has the data on claims paid on behalf of each beneficiary, it could then calculate an appropriate capitation rate.

Questions that would be answered in this demonstration include the degree of willingness of employers to accept capitation payments for Medicare enrollees and the extent to which these plans are successful in competing with Medicare. The research design of choosing market areas for which the regulations could be relaxed would apply to this demonstration as well, but would be less important than for the other demonstrations. To date, only a handful of volunteers have approached HCFA, so that a market-by-market approach may be inconsistent with early testing of this concept.

Capitation Payment for Part B Only

As discussed in Sec. IV, Medicare might be able to attract additional organizations to provide services to Medicare beneficiaries on a capitation basis if the plan were at risk only for Part B services. For example a multispecialty group of physicians might find it more advantageous to be at risk only for physicians' services, most of which would be provided by the group itself, than for hospital services as well.

With a number of serious drawbacks to this option (see Sec. IV), such a demonstration might not be accorded very high priority. HCFA's approach might be similar to that suggested for broadening plan qualification requirements—consideration of granting a waiver only when attractive proposals appeared.

In contrast to the demonstrations discussed above, a research design would not need to focus on market areas but could focus on plans

instead. Whereas the above demonstrations would test the effects of changing policies toward a well-established organizational form, this demonstration would be testing a new type of organization. Hence, the unit of analysis would be a health plan, rather than a market.

Marketing Support

Under current policies, HMO/CMP marketing is left to the plans. HCFA does not devote resources to informing the beneficiaries of private health plan options available to them.

A higher-level marketing campaign by Medicare would be a suitable demonstration. Two models might be tried. Medicare could follow the model of the Federal Employees Health Benefits Program by annually informing beneficiaries of qualified plans operating in their area and sending uniform plan descriptions. Alternatively, Medicare could offer grants to local consumer organizations to increase beneficiaries' awareness of the private plan options that are available to them. The latter would be more consistent with the Administration's philosophy of decentralization but would be more expensive, since each consumer organization would have to incur the expense of planning a marketing program.

Increased marketing efforts could increase enrollment in private plans, perhaps substantially, though at some gross cost to the program. Net outlays could be reduced, however, so long as adverse selection did not offset the theoretical 5 percent reduction in outlays from each new enrollment in a private health plan. In any case, capitation payments could be reduced to fund the costs of marketing incurred by HCFA.

Two research design options could be considered. First, the treatment could be applied to selected market areas, with others used as controls. Alternatively, if funds limited the demonstration to a small number of market areas, a randomized design within an area could be employed, where only a sample of beneficiaries received the information. The latter design would exclude mass media techniques, however.

Increased marketing is one option where phased implementation is an alternative to a demonstration. The only risk inherent in pursuing such a policy is wasting some money. Since a well-designed policy implementation would produce as much information on cost effectiveness as a demonstration, and would not be difficult to retract if found not to be cost effective, such an approach might be favored over a demonstration. In either case, research on existing demonstrations in this area might yield valuable information in the near future.

Voucher to the Beneficiary

Under such a demonstration, each beneficiary would receive once per year a voucher indicating the amount that Medicare will pay toward a qualified private plan. If the voucher were not used within a defined period, it would expire and the beneficiary would continue to receive regular Medicare benefits.

Presuming that health plans would have to meet the same requirements as under current policies, the implications of a voucher to the beneficiary concern only marketing and administration. A beneficiary would receive the same opportunities to enroll in private health plans as under current law and would have the same amount paid toward the health plan's premium. Although much can be said for increased funding of marketing activities on the part of HCFA, there is no need to label the provision of more information as a "voucher to the beneficiary."

A voucher to the beneficiary would not imply any deregulation of Medicare payments to private health plans. All of the deregulation options discussed above could be put into effect without a voucher to the beneficiary. They all involve what requirements private health plans must meet, and apply whether all of the financial transactions are directly between Medicare and the health plans or not.

There are political perils in labeling a new marketing approach as a voucher, however. The term "Medicare voucher" is read by many as a mandatory voucher (see Sec. IV). Mandatory vouchers are seen not as a private health plan strategy but as a device to transform Medicare from an entitlement to comprehensive medical services to a fixed dollar indemnity—a tool to reduce benefits. Many who went along with the TEFRA provisions authorizing capitation payments to private health plans would not support a voucher. If the Administration is to succeed in its goal of containing Medicare costs through a more widespread use of private health plans, it must keep that strategy separate from steps to change the nature of the Medicare entitlement.

Refinements to the AAPCC

Under current policies, capitation payments vary according to age, sex, institutional and welfare status, and county of residence. Although this variation is better than a uniform capitation rate, it is not a very good predictor of the use of services in the fee-for-service sector (Sec. V).

Two problems arise from lack of refinement in the mechanism to set payments. First, health plans are exposed to the risk of enrolling a

group of beneficiaries who have higher medical care needs than average for their cohort. Such risk makes serving the Medicare population on a risk basis a less attractive opportunity. Second, Medicare is vulnerable to preferred risk selection on the part of the health plans or the enrollees. If plans are able to selectively market to healthier beneficiaries or design their services to be more attractive to those who are healthy, then the capitation payment from Medicare will be too high. The program is also at risk of healthier beneficiaries being more inclined to enroll in private health plans.

Section V reviewed an extensive range of options for refining the AAPCC. Demonstrations could test out some of them. Market areas could be chosen to have capitation rates set in a different way and compared to other market areas that continue under the present system.

However, refining the AAPCC may be an area where changes should be made now and major demonstrations reserved for the next generation of refinements. The cost of delay is high here, and some of the options have only limited risk of having negative effects. Perhaps, reforms to the AAPCC could be applied to all but a few market areas, which would be held back to assess the effects of what has been done.

Demonstrations in this area might instead be short term, focusing on the area of administrative feasibility.

Mandatory Vouchers

We doubt both the political feasibility and the wisdom of demonstrating mandatory vouchers at this point. Mandatory vouchers are viewed by many as an end to the Medicare entitlement. It is difficult to imagine the Congress standing idly by as an area is chosen for a mandatory voucher demonstration. An initiative for such a demonstration is likely to risk the support for the current program of voluntary enrollment in qualified private health plans.

As discussed in Sec. IV, we believe that the Medicare private health plan strategy must pass a market test before such enrollment can be made mandatory. Private health plans must be shown to be able to attract and retain a large enough proportion of Medicare beneficiaries before elimination of the standard Medicare option can be contemplated. Any evolution to a mandatory voucher should be pursued in two steps. Once a threshold of enrollment is reached, then the capitation rate might be based on the experience of private health plans and a premium charged for standard Medicare. If that point were reached, the main goal for a mandatory voucher would have been accomplished, and whether standard Medicare is retained or not would not have a major implication for the strategy.

VIII. ADDITIONAL PRIVATE HEALTH PLAN OPTIONS

This section discusses two options involving Medicare payments to private health plans that are not as strongly rooted in Section 114 of TEFRA as the options discussed in Secs. IV, V, and VI.

The first involves a capitation payment to a private insurer who provides both the traditional Medicare benefits and alternative health plans to all Medicare beneficiaries in a geographic area. It is often referred to as "geographic capitation," although the terms "intermediary-at-risk" and "carrier capitation" have also been used.

The second involves offering PPA arrangements to beneficiaries. The discussion includes both having Medicare develop a PPA and granting a franchise to one or several private organizations to do so.

GEOGRAPHIC CAPITATION

Description

The Reagan Administration has focused on five Medicare objectives:

- Slowing the increase in federal expenditures,
- Making federal expenditures more predictable,
- Shifting financial risk to private individuals and organizations,
- Improving incentives for efficiency, and
- Stimulating competition among health are providers and financing entities (e.g., HMOs and CMPs).

In its effort to meet these objectives, HCFA has entertained demonstration projects testing the concept of "geographic capitation." Under geographic capitation, HCFA would shift to a private insurer ("the primary insurer") all or nearly all the financial risk for financing Medicare services in a geographic area, for example, a state. Enrollment with the primary insurer would not be optional, as with HMOs and CMPs; Medicare beneficiaries would be required to convert from government insurance to private insurance. HCFA would pay the primary insurer a fixed capitation amount per beneficiary.

HCFA would require the primary insurer to maintain a "current-law option" for Medicare beneficiaries—that is, a plan similar if not identical to the current Medicare program. Under this option, covered

services, patient cost sharing and premiums, and the rules governing payment to providers would be the same as under current law. So far as possible, even utilization review standards would be held constant. The current-law option would assure beneficiaries that geographic capitation is not undermining traditional Medicare benefits.

Each beneficiary would be automatically enrolled in the current-law option unless he or she made a conscious decision to enroll in another plan offered by the insurer or TEFRA-qualified HMOs and CMPs. Beneficiaries would not be permitted to drop coverage altogether in exchange for a cash rebate. The primary insurer would be free to offer alternatives to the current-law option. The alternatives may or may not be required to meet Section 1876's requirements for HMOs and CMPs. Beneficiaries would also be permitted to enroll in independent HMOs and CMPs, so long as the plans qualified under Section 1876.

Potential Advantages

On its face, geographic capitation seems an effective way to slow the increase in federal expenditures, making Medicare expenditures more predictable, and shifting financial risk to private parties. These objectives may not be easily attained in practice, however.

The rate of increase in federal expenditures would depend on the formula used to pay the primary insurer. At a minimum, HCFA would want to spend no more than would have been spent without geographic capitation. Although Medicare expenditures have become more predictable since the advent of PPS, HCFA may still make significant errors in forecasting inflation and utilization trends. Because it would be at risk for total costs, the primary insurer would be at risk for those errors, just as HCFA would be at risk for overestimates. Forecast errors could overwhelm the private insurer's potential for lowering costs through improved efficiency. Insurers may therefore demand retrospective adjustments to reflect actual inflation rates and perhaps even utilization. Because the primary insurer would have little opportunity to influence use under the current-law option, insurers may be unwilling to assume the risk for significant errors in utilization projections.

The first four Administration goals listed above are inextricably intertwined. Outlays cannot be reduced, predictability cannot be increased, and risk cannot be shifted unless private insurers believe they can save money by improving efficiency. Geographic capitation could improve efficiency in two ways: by encouraging the primary insurer to process and review claims efficiently under the current-law option and by encouraging the primary insurer to move Medicare beneficiaries into alternative delivery systems offering managed care.

Geographic capitation would give the primary insurer strong incentives to process claims efficiently, even stronger incentives than those faced currently by fiscal intermediaries and carriers. But improved claims processing would yield only limited savings; as noted above, only 2 percent of total costs are administrative. More significant savings could come from establishing new standards of appropriate medical practice in the current-law option, yet that avenue would appear to be blocked. Significant changes would be inconsistent with the concept of a current-law option.

On the other hand, large savings could be achieved by moving beneficiaries into managed care, particularly if chronically ill patients were included. The primary insurer would have a strong incentive to promote managed care for potentially high-cost patients, since it is at risk for total expenditures. As discussed in Sec. V, HMOs and CMPs face very different incentives; they have an incentive to enroll only the healthiest Medicare beneficiaries in any given AAPCC category. Since Medicare's capitation payment is fixed without regard to the health care needs of individual enrollees, an HMO/CMP could profit from enrolling low-risk patients.

The primary insurer may have difficulty persuading high-cost patients to leave the current-law option. Patients with chronic illnesses may be reluctant to accept managed care if it requires severing established relationships with health care providers. *Requiring* high-cost patients to enroll in managed care would be inconsistent with the need to maintain a current-law option.

The primary insurer would also likely face competition from independent HMOs/CMPs. Unless the primary insurer's managed-care option is freed from the regulations on HMOs/CMPs, the insurer may see little advantage in assuming the risk for total program costs. Without some competitive advantage on HMOs/CMPs, the insurer could do as well offering its own HMO/CMP under Section 1876, leaving HCFA to bear the financial risk for those not enrolled in capitated plans.

Assuming that HCFA shifts all financial risk to the primary insurer, the federal government would be sheltered against the budget effect of selection patterns. That is not to say, however, that geographic capitation solves the problem of adverse selection—at least not so long as beneficiaries may enroll in HMOs/CMPs not underwritten by the primary insurer. The primary insurer could be victimized by adverse selection if HMOs/CMPs enroll the healthiest beneficiaries in any given payment category. As under current law, HMOs/CMPs would also face the risk they will be victimized by adverse selection. In short, geographic capitation shifts the risk of adverse selection to private health plans, but it does not eliminate the problem.

Potential Disadvantages

The Administration's fifth major goal is to stimulate competition among health care providers and financing organizations. Geographic capitation would probably do little to promote competition, and it may actually reduce competition.

To serve as the primary insurer, an insurer must be quite large. Small insurers could not assume the huge risk inherent in underwriting care for all senior citizens in the area, particularly in view of the potential for preferential selection by HMOs/CMPs and the risk of errors in forecasts of inflation and utilization.

Even a large insurer would want to assure itself that the risk from adverse selection is small. Since selection risk is influenced by the level of enrollment in independent HMOs/CMPs (i.e., those not sponsored by the primary insurer), an insurer may elect to proceed only if persuaded that enrollment in independent plans would be small. At least in the short run, then, geographic capitation may not be feasible in areas where there is vigorous competition among independent plans.

An insurer's willingness to assume selection risk may increase if the Medicare contract had the potential to yield significant spillover benefits for its non-Medicare business. For example, the insurer might conclude that enrolling Medicare patients in its existing alternative delivery systems would greatly increase its ability to demand low prices from health care providers. If that is true, however, geographic capitation might permit an already dominant insurer to extend its market power to the market for managed care, making it difficult for independent HMOs/CMPs to compete. HCFA should thus be wary of exempting the primary insurer's alternative delivery systems from the rules in Section 1876.

To remedy this problem, HCFA could require the primary insurer to maintain separate plans for Medicare and private patients. Separating Medicare patients from private patients would be inconsistent, however, with Section 1876. Section 1876 limits the proportion of Medicare enrollees in any given HMO/CMP in the belief that the presence of non-Medicare enrollees helps protect the quality of care. Of course, requiring separate plans may also eliminate the reason an insurer is willing to assume the risk of serving as primary insurer.

Proponents argue that geographic capitation is consistent with a more competitive market, if HCFA would periodically open the contracts to competitive bidding. There are several problems with this argument. First, only a limited number of insurers are capable of assuming the financial risk, limiting the number of potential bidders. Second, competitive bidding for ill-defined services is difficult;

competitive bidding works best with tangible products, the quality of which can be readily determined. The obligations of a primary insurer, in contrast, cannot be reduced to simple specifications; they must be negotiated with HCFA and monitored continuously.

Third, changing primary insurers at the end of a contract period may be politically difficult after an insurer has made such a large financial and administrative commitment to Medicare. For example, denying renewal of a contract may jeopardize the insurer's solvency or disrupt the processing of Medicare claims. Fourth, frequent competitive bidding may be resisted by insurers, who may demand long-term contracts to serve as primary insurer. Without a long-term contract, the insurer may not be willing to invest in the necessary administrative systems.

By accepting bids only from insurers with small market shares, HCFA could reduce the risk that geographic capitation would enhance the market power of an already dominant insurer. Some commercial insurers, for example, may be large enough to bear the financial risk, but their existing business may be evenly dispersed across the country, leaving them with only a small share of any given market.

Limiting participation to insurers with small market shares may, however, preclude many of Medicare's current fiscal intermediaries and carriers from qualifying for contracts. That could significantly reduce the competition for the contracts, since existing carriers and intermediaries would likely be among the most interested insurers. Intermediaries and carriers have already made the requisite investment in data systems, and some could ill afford to lose their contract to process Medicare claims.

Another potential problem is that insurers with widely dispersed policyholders may not have the requisite relationships with health care providers to support systems of managed care. Finally, an insurer without a significant amount of business in the market may insist upon a longer contract. The longer contract may be necessary to permit the insurer to recoup its investment in vastly expanding its local operations.

Conclusion

The wisdom of geographic capitation cannot be judged in the abstract. Both the potential advantages and problems depend on the specific circumstances. Moreover, HCFA may find that geographic capitation is a useful tool for pursuing some of the Administration's goals, while hindering the pursuit of others.

The option is best pursued through demonstrations rather than through legislation. HCFA could issue guidelines to potential demonstrators, indicating which types of arrangements are the best candidates, and further screen proposals on the basis of potential. Significant attention should be paid to the ability to evaluate, since suitable comparison groups may not always be available.

MEDICARE PPAS

A PPA gives insured persons incentives to choose providers from among a subset of those available to them. The preferred providers are chosen by the insurer or third party administrator on the basis of low costs and other factors. The low costs may be a reflection of a relatively efficient practice style, low fees, a discount to the PPA, or a willingness to submit to intensive controls on use.

As with many new organizational forms, a consensus has not yet developed concerning definitions. The incentives to use a panel of preferred providers distinguishes PPAs from traditional insurance. Two characteristics appear prominent in distinguishing PPAs from HMOs. Providers tend not to be at risk in PPAs. Risks are borne by either employers (in self-insured plans) or insurers. Also, PPAs allow insured persons to use providers not on the preferred panel if the patient is willing to pay deductibles and coinsurance. PPA-like arrangements that do not pay benefits when outside providers are used are called EPOs (exclusive provider organizations). EPOs are conceptually similar to HMOs, although they may not be incorporated as HMOs under state law.

Given the rapid spread of PPAs in the private sector, one should consider whether they could play a role in the Medicare program. Medicare already has an important element of a preferred provider organization. In Part B, physicians are permitted to charge the beneficiary the difference between the Medicare reimbursement and their actual charge, up to limits established under the Omnibus Budget Reconciliation Act of 1986. Since 1984, however, Medicare has had a category of "participating physicians" who have agreed to accept assignment on all services and not bill patients for the difference between their actual charge and what Medicare allows. Medicare in turn provides beneficiaries with a list of participating physicians in their area. Thus beneficiaries have the option of limiting themselves to participating physicians and having lower out-of-pocket expenses as a result. In this arrangement, Medicare is giving any physician willing to sign the participation agreement the opportunity to be included in the

preferred panel. Since Medicare (once the PPS transition is complete) pays all hospitals in a local market the same amount, and additional charges to beneficiaries are not permitted, there are no PPA-type features in Part A.

PPAs in the Private Sector

In the private sector, one can identify a number of distinct types of PPAs. The key differences involve the types of consumer incentives to use preferred providers, methods for selecting the providers, and methods of paying the providers.

Variation in incentives to subscribers is significant. The most common arrangement is offering lower cost sharing when a preferred provider is used. Thus, the beneficiary decides on a service-by-service basis whether to use the PPA. This approach is analogous to Medicare's participating physician program.

Generally, this arrangement is feasible only if the basic indemnity plan has substantial cost sharing. Otherwise, there is insufficient basis to provide an incentive to the beneficiary to use the preferred providers. One exception is a plan offering additional coverage of preventive services through PPA providers. The plan's hope is that the same providers would continue to be used for curative services despite the absence of direct incentives.

Employers who have benefits without significant cost sharing may offer a PPA as an enrollment option. In this way, a lower premium contribution by the employees can be used as an incentive. Expanded coverage can also be offered. Although some enrollment PPAs restrict choice of providers to those in the network (a "lock in"), most require additional cost sharing only when care is obtained through outside providers.

The method through which the panel of preferred providers is selected often depends on the type of entity organizing the plan. Some PPAs are organized by a group of hospitals, which in turn invite their medical staffs to join. The lead hospital chooses others believed to have low costs and high quality that serve other parts of the metropolitan area. Although a PPA could be a single hospital, the lack of area coverage would tend to make it unattractive to employers in major metropolitan areas. Insurer-sponsored plans attempt to analyze which providers have the lowest costs. This tends to be most feasible for choosing hospitals—physicians tend to be chosen on the basis of their membership on the staffs of the selected hospitals. Discounts offered by hospitals are also a factor in this choice. Independent brokers use procedures that are similar to those used by insurers. Few PPAs

attempt to select physicians on the basis of low-cost practice style, though many talk of their plans for dropping high-cost physicians.

PPAs in Medicare

The following subsection discusses alternative ways that Medicare could offer PPAs to its beneficiaries.

Organization. Before discussing beneficiary incentives to use preferred providers and methods of selecting and paying providers in a Medicare PPA, it is important to consider what entity should organize it.

Medicare could organize the PPA itself, as many private insurers have done. An advantage would be its large market share, which could be an important asset in obtaining favorable prices from providers. Lack of flexibility would be a problem, however. As a public program, Medicare might have difficulty selecting providers by any criteria other than the most objective—such as the lowest price. Presumably, a model resembling the selective contracting practiced by California's Medi-Cal program could be used. Although obtaining a low price is important in this program, the objective must be compromised when necessary to secure sufficient access in each area that beneficiaries live. The inability of a public program to select a hospital that has a slightly higher price but is much more popular among beneficiaries could limit the attractiveness of the PPA.

To the extent that Medicare's participating physician concept is essentially a PPA for physician services, Medicare might limit its initiative in this area to choice of hospitals. One possibility would allow hospitals to offer a rebate of all or a portion of the hospital deductible. This would permit incentives to beneficiaries to use those hospitals with the lowest costs, perhaps remedying one of the problems with PPS. A potential disadvantage would be the likely increased rate of hospital use resulting from lower deductibles for those sensitive to price. Also, the majority of beneficiaries have Medigap coverage, so such rebates would not be effective incentives for them.

Since the Administration's philosophy emphasizes contracting with private organizations wherever possible, Medicare could allow private entities to develop PPAs for it. If beneficiaries were allowed a choice of whether to use PPA providers on a service-by-service basis, however, only one organization per area could be authorized to develop a PPA for Medicare. Such a franchise could be awarded competitively, but the competition would be to satisfy government officials at one point in time rather than to appeal to consumers on an ongoing basis. As a result of having a franchise, the PPA organizer might also be subject to

the same pressures to avoid the use of subjective criteria as Medicare would if it organized the PPA itself.

Indeed, since Medicare would be at risk, it would have to exercise close supervision over the private entity organizing the PPA. (If Medicare were not at risk, this would be the carrier capitation or intermediary-at-risk option, which was discussed above in this section.) This would further reduce the flexibility of the private organization. Such a model would resemble Medicare contracting for claims processing and other services from intermediaries and carriers. Medicare plays an important role in specifying the degree of stringency in claims review by carriers, although the lack of incentives on the part of the contractor lessens this control.

Instead of a single entity developing a PPA for Medicare, a number of organizations could be authorized to do this in each area, with beneficiaries enrolling in one of them (as an alternative to either enrolling in an HMO/CMP or remaining in traditional Medicare). With competition among these plans, more flexibility could be realized. Plans would not be restricted to using cost as the only criterion with which to select providers.

But with Medicare at risk, the private entities would have the wrong incentives. They would seek to include the most popular providers without regard to cost. Medicare, of course, would seek to avoid this by careful evaluation of bids to be authorized, but the political pressures that HCFA is subject to, and the lack of knowledge of local providers, would leave this divergence of incentives as a serious problem. The difficulty that all payers have in assessing the cost impact of offering a PPA opens the risk of this divergence in incentives being costly to the program. This problem is also present when a single private entity is given a franchise, but the divergence in incentives is likely to be more serious when a number of plans are competing for patients. A plan willing to accept the insurance risk would be able to qualify under current law as a CMP.

Beneficiary Incentives. If Medicare either developed the PPA itself or franchised a private organization to do so, it could either allow beneficiaries to decide whether to use PPA providers on a service-by-service basis or to offer the PPA as an enrollment option.

While either would be feasible, an enrollment option might be more suitable for Medicare. Although the Medicare benefit structure certainly leaves room for incentives of lower cost sharing, with its $520 hospital deductible and 20 percent coinsurance for physicians' services, the majority of beneficiaries have supplemental policies that "fill in" all or parts of these amounts. Thus, for the incentives to be effective for large numbers of Medicare beneficiaries, coordination with decisions to

renew supplemental policies would be important. With enrolling in a Medicare PPA a periodic decision, it could be coordinated with decisions concerning supplemental policies, which offer little to a beneficiary willing to limit choice to PPA providers.

One should not rule out the nonenrollment model, however, since this could be very attractive immediately to those without supplemental coverage. The experiences of this group might over time induce substantial numbers of those with coverage to drop it and use preferred providers.

The PPA benefit structure might focus on reducing the hospital deductible. With PROs currently administering preadmission certification programs (and the potential for a PPA to conduct a more stringent utilization review activity), the utilization reduction effects of cost sharing may become less important for hospital care. On the other hand, neither PROs or PPAs have done much to control use of outpatient services, so the remaining cost sharing should focus on those services.

A Medicare PPA would have to devise a method of selecting preferred providers. As mentioned above, price would have to be the key criterion in Medicare's choice of providers. For hospitals, Medicare could either establish a uniform discount from current DRG rates or develop competitive bidding to be in the preferred network. The latter would be preferable, since it could be tailored to local market conditions. A uniform discount might bring too few hospitals in some areas and too many (meaning the rate is too high) in others. A competitive bidding framework would require substantial development work, though the Medi-Cal experience in California would be a useful guide.

Bidding could also be used for physicians' services but might be unworkable because of the large number of physicians to be included in a preferred panel and the large number of types of procedures. A more workable approach would resemble the participating physician program used today. Medicare might announce a fee schedule, and physicians would become members of the preferred panel by agreeing to accept such fees as payment in full (except for the required deductibles and coinsurance). The fees would be somewhat lower on average than Medicare "reasonable" charges. The relative fees might reflect current consensus regarding which procedures are relatively overpriced.

Coordination between hospital and physician preferred panels could pose a problem. Although a beneficiary might be attracted to enroll in or plan on using the PPA because of its panel of hospitals being acceptable, he or she would have little way of knowing about the proportion of physicians practicing at that hospital who participate in the preferred panel. Similarly, physicians with large hospital practices

would be interested in participating as a preferred provider only if the hospital at which they practice were part of the preferred hospital panel. Otherwise, the discounts they agreed to would generate few additional patients.

Dealing with the coordination problem would require a two-step approach. First, hospitals would be selected and then physicians associated with the preferred hospitals would be invited to join. Other physicians could also be invited to participate. Participation might be attractive to some physicians with predominately outpatient practices. For inpatient services, however, physicians practicing at hospitals other than those on the preferred panel would be at a substantial competitive disadvantage because patients could gain larger incentives by using a preferred physician practicing at a preferred hospital.

Outlay Implications

Whether offering a PPA would reduce Medicare outlays is not clear. Medicare would pay less for hospital and physician services from preferred providers but would pay a higher proportion of the bill through lower cost sharing. Higher rates of use might also be experienced. Either a demonstration or a trial and error process with careful assessment would be needed to ascertain the outlay implications of a Medicare PPA. What is clear, however, is that beneficiaries using the preferred providers would be better off, and providers as a group would receive less revenue from service to Medicare patients than they would in the absence of a PPA.

More uncertainty concerning outlay implications would accompany enrollment PPAs. Biased selection in enrollment decisions is likely, so that premiums would have to be adjusted for it. Accurately assessing current patterns of selection for use in setting the next year's premium would be important. Although no research is available on patterns of selection of PPAs, we suspect that PPA enrollees would tend to be lower than average users. Thus, not taking biased selection into account when setting premiums risks setting premiums too low to maintain budget neutrality.

Research and Demonstrations

The participating physician program authorized in the Deficit Reduction Act of 1984 has many characteristics of a PPA. Participating physicians accept assignment on all services to Medicare patients and are included in directories. An evaluation of the experience under this program could shed important light on the prospects of PPA-like innovations in Medicare.

A demonstration of a Medicare PPA would be a valuable endeavor. We could learn most from a demonstration run directly out of Medicare with enrollment of beneficiaries. This model would permit the most powerful research design.

HCFA would need to look for two qualities in a contractor to conduct and evaluate the demonstration. First, the contractor should have experience in designing, conducting, and evaluating demonstrations. Second, the contractor should be experienced in developing and managing PPAs. Insurers are likely to have PPA experience that is most relevant to Medicare. They might be retained as subcontractors to the demonstration contractor.

Conclusion

A Medicare PPA appears to be a feasible endeavor. It holds the potential for at least saving money for those beneficiaries who use preferred providers and might reduce outlays as well. A Medicare PPA has somewhat less potential than one that is part of an employment-based health plan, however. First, Medicare already gets substantial discounts for health services, particularly hospital care, so that the potential for additional savings is more limited. Second, less flexibility in choosing the panel of preferred providers may mean a PPA of only the lowest-priced providers, which may be far less attractive to consumers.

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